

ATTACHMENT C
SERVICE STANDARDS
(August 15, 2008)

SERVICE STANDARD	PAGE
CAMP	2
CARE NETWORK	6
CHILD ADVOCACY CENTER	13
CROSS-SECTION CARE COORDINATION	18
DOMESTIC VIOLENCE	25
DRUG TESTING AND SUPPLIES	50
EMERGENCY/MOBILE DRUG SCREENS AND TESTS	55
RANDOM DRUG TESTING	59
RESPIRE CARE AS A PREVENTION SERVICE	64
TRUANCY TERMINATION	71
TUTORING/LITERACY CLASSES	75

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CAMP SERVICES-PREVENTION & INTERVENTION

I. Service Description

These services are designed to provide Indiana's Children with a safe and nurturing environment while respecting their dignity and individuality and helping children to reach their full potential.

The purpose of these services is to enrich the lives of children and build tomorrows that will allow children served to make a lasting contribution to society. This is not for treatments such as wilderness and boot camps.

Examples:

Sports camps

Day camps

Overnight camps

Camps should be committed to a safe and nurturing environment with caring, competent adult role models, and should provide healthy and developmentally-appropriate experiences. Camps should also allow children the opportunities for leadership and personal growth, provide discovery experiential education, learning opportunities, and excellence and continuous self-improvements for Indiana Children.

It is expected that the referring source and provider will work together to make arrangements for children to attend camp. The provider will monitor the progress of the children attending camp and report to referring source as appropriate, and agreed on prior to camp experience.

II. Target Population

Services must be restricted to the following eligibility categories:

Target Population - Prevention	Target Population - Intervention
<ul style="list-style-type: none">• Children and families for whom a child protection services investigation has not been substantiated• Families that have been referred by a community partner or who self refer due to a determination that, with timely, effective and appropriate prevention support services, family functioning can be improved and child abuse and neglect prevented	<ul style="list-style-type: none">• Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment• Children with a statue of CHINS, and or JD/JS• All adopted children and adoptive families

III. Goals and Outcome Measures

Prevention:

Goal # 1 Prevent families from entering the DCS system

Outcome measure: 100% of families participating in camps will report no involvement with CPS

Goal #2 Youth will attend camps on a consistent basis

Outcome measure: 100% of youth referred will report regular attendance and participation in camp activities

Goal #3 Family satisfaction with services

Outcomes measure: 100% of families who have participated will rate the services “satisfactory” or above

Intervention:

Goal #1 Timely intervention with the family and regular communication with camp personnel

Outcome measure: 100 % of all referred youth will have face to face contact with camp personnel to verify camp attendance and participation

Goal #2 Family satisfaction with services

Outcome measure: 100% of families who have participated will rate the services “satisfactory” or above

IV. Staff Qualifications

Staff should adhere to national and state health and safety standards that include first aide and CPR training. In the area of special needs, staff should have the appropriate certifications to work with targeted special needs children. Current certifications must be maintained on file at the camp. For expired certifications, the date of scheduled re-certification courses may be listed when staff is registered to attend camp.

I. Camp Qualifications

Camps are encouraged to have American Camp Association (ACA) accreditation. All camps must meet local, state and federal laws, regulations, and policies that govern their particular operation.

II. Criminal Background Checks

For camp providers, a “background checks” will consist of the following criminal (or juvenile) and civil history checks:

Department of Child Services
Regional Document for Child Welfare Services
Term 1/1/09 to 6/30/11

1. Fingerprint-based National Criminal History which includes Indiana State Juvenile History and fingerprint-based Indiana State Criminal History check.
2. Sex and Violent Offender Registry
3. Child Protection Service History
4. Local law enforcement agencies (LEA) county sheriff records

III. Billable Units

The billable unit for camp will be the actual cost of the camp experience.

Translation or sign language

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

IX. Rates

Camp Rates: Actual cost
 Translation/Sign Language: Actual Cost

A provider does have the option of submitting an RFP to become a contracted provider with the State of Indiana. In the event that an RFP is submitted by the provider, a budget summary must be submitted for rate determination.

I. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form, or a prevention referral form authorizing service
- 2) Documentation of contact with the referred families/children
- 3) Written reports frequently as prescribed by referring source
- 4) In the event of absenteeism by client, the provider must contact the referring source to determine if continuation of services is appropriate.

II. Service Access

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral form. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

Note: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form. In emergency situations, services may begin

with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CARE NETWORK SERVICE STANDARD**

I. Service Description

Care Network encompasses the part of the system of care that focuses on coordinating, integrating, facilitating and monitoring services for children with behavioral health needs who are in the child welfare or juvenile justice system.

This system of care is based on a comprehensive spectrum of services which are organized into a coordinated network to meet the multiple and changing needs of children with severe emotional disturbances and behavioral challenges and their families.

Services in the system of care should be comprehensive, incorporating a broad range of services and supports, individualized, provided in the least restrictive appropriate setting coordinated at the system and service delivery levels, involve youth and families as full partners and emphasize early identification and intervention. Core values of a system of care are that services are child centered and family focused, community based and culturally competent.

Services include providing any requested testimony and/or court appearances including hearings or appeals.

Services within the network will include but are not limited to the following:

1) Behavioral Health Services

- Behavior Management Services
- Crisis Intervention
- Day Treatment
- Evaluation / Testing Services
- Family Assessment
- Family Therapy
- Group Therapy
- Individual Therapy
- Parenting/ Family Skills Training Groups
- Special Therapy
- Substance Abuse Therapy- Group
- Substance Abuse Therapy- Individual
- Family Preservation – home based services

2) Mentor Services- hourly

- Case Management
- Clinical Mentor

- Educational Mentor
- Life Coach/ Independent Living Skills Mentor
- Parent and Family Mentor
- Recreational/Social Mentor
- Supported Work Environment
- Tutor

3) Other Services

- Consultation with Other Professionals
- Team Meetings
- Transportation

4) Psychiatric Services- hourly

- Assessments Outpatient
- Medication Follow-up/ Psychiatric Review

5) Respite Services

- Crisis Respite
- Planned Respite
- Respite-Residential or Hospital 23 Hour

6) Supervision Services

- Community Supervision
- Intensive Supervision

II. Specific Responsibilities

1) The Care Network Facilitator conducts the following activities for the system of care:

- Evaluates and interprets referral packet application and completes a strength-based assessment with child and family and the Child and Adolescent Needs and Strengths Assessment (CANS);
- Schedules and facilitates in coordination with the DCS Family Case Manager (FCM) family/child specific team meetings;
- Address need for and develop, revise and monitor in a crisis plan with family and team members;
- Monitor progress by communicating with the family and child, as well other team members through no less than monthly team meetings;
- Maintains comprehensive reports based on services and assessments while providing information to FCM and team members every 30 days, reassess child using CANS every 6 months;
- Makes recommendations to team members based on monthly assessments and service reports;
- Assist the family and child with gaining access to services and assuring that families are aware of available community-based services and other resources

such as Medicaid State Plan services, Vocational Rehabilitation programs, educational, and public assistance programs; mental health and addiction services as indicated;

- Monitor use of service and engage in activities that enhance access to care, improve efficiency and continuity of services, and prevent inappropriate use of services;
- Monitor health and welfare of the child/youth;
- May provide crisis intervention.

2.) Providing agency receives referrals 24 hours a day, 7 days a week. There is a verbal determination between DCS, the family and the agency that services are warranted, and there is agency availability for the service before the referral is sent.

3.) The face- to- face intake must occur no later than the end of the day following the referral.

4.) Assessments including the goal setting and service plan are mutually established between the client, care facilitator and FCM with a written report signed by the family and care facilitator, submitted to the DCS referring worker within 7 days of the initial face-to-face intake and every 30 days thereafter. Communication between the care facilitator and DCS is constant and documented as arranged between the two.

5.) Each family receives access to services through a single care facilitator acting within a team, with availability 24 hours a day 7 days a week.

6.) Family functioning assessments, assessments of caretakers needs through the CANS, the family's response, presenting problems according to DCS referral are factors included in the goal setting. Goals are behaviorally specific, measured and attainable.

7.) Safety is of paramount importance. If there are indications about safety concerns within the home there is an obligation for the care facilitator and DCS to communicate to address all safety concerns, and document safety steps taken to resolve the issues. If new incidences occur, the care facilitator is to notify DCS immediately of the situation.

8.) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement. Appropriate release forms will be requested and signed by family members and DCS before information is shared with team members or others.

III. Target Population

Services must be restricted to cases where severe emotional disturbances and/or behavioral problems have been documented within the following eligibility categories:

- 1) Children and families with a case type of Informal Adjustment (IA) with moderate to high levels of risk and service needs according to the DCS assessment matrix; and,
2. Children with a status of CHINS, and/or JD/JS (Juvenile Delinquency/Juvenile Status); or,
3. All adopted children and adoptive families

IV. Goals and Outcome measures

Goal #1: Provide high quality care which results in improved outcomes for the child and family.

Improved child and family functioning

A.) Improved school functioning from case opening to closure

- An increase in scores as found on grade reports in 85% of cases
- Decrease in absenteeism/truancy as reflected by attendance reports in 85% of cases
- A decrease amount in behavior reports in 85% of cases
- A decrease in suspension/expulsion reports in 85% of cases

B.) Improved records with the child welfare and juvenile justice system

- 85% of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home during involvement
- 85% of families show improvement and child(ren) remain at home.

C.) Progress in service coordination plan

- Measured by monthly team report and Care Facilitator plan of care

D.) Fewer days in out of home placement (the provider will track and report as a part of evaluation the number of continuous days in placement for each child).

- Information submitted will be evaluated by DCS against DCS data.

E.) 50% of the children and families will have statistically significant improvement in any life domain on the CANS (functioning, behavioral health systems, risks, caretaker needs and strengths, child strengths)

V. Qualifications

Supervisor

1. Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related Human Services field; and,
2. A current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following:
 - Clinical Social Worker
 - Marriage and Family Therapist

- Mental Health Counselor

Care Network Facilitator

1. Bachelor's Degree in Social Work or related Human Service field; and,
 2. Minimum of three years of clinical/management experience in human service field; and,
 3. Demonstrated 2 or more years of clinical intervention skills; and,
 4. Demonstrated skill in fiscal management activities, team building and development.
- Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

The Care Network Facilitator assures care is delivered in a manner consistent with strength-based, family centered, and culturally competent values, offers consultation and education to all providers regarding the values of the model, monitors progress toward treatment goals and assures that all necessary data for evaluation is gathered and recorded.

VI. Billable Units

The Care Network Facilitator and team will determine what services a child/family needs and what they may be eligible for and can use flex funding when services cannot be accessed through other available State contracts. Services recommended by the Continuum of Care Facilitator that don't have other state contracts will have the ability to be reimbursed on a dollar for dollar basis with flexible funding.

- Requested testimony and/or court appearances including hearings or appeals as requested and approved by the DCS.

Face to Face time with the client (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family):

- 1) Includes any client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- 2) Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- 3) Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- 4) Time spent with service providers on behalf of the client/family to plan and monitor services and progress.

Reminder: *Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time, no show and planning, and report writing for*

family meetings. These activities are built into the face to face rate and shall not be billed directly.

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are rounded to the nearest quarter hour using the following guidelines:

8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

Translation or sign language:

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client - dollar for dollar amount.

VII. Rates

Face to Face Maximum Rate: _____

Translation or Sign Language Rate: Actual Cost

Flexible Funding: Actual Cost

Provider must provide a budget summary for Face to Face Rate.

VIII. Case Record Documentation

Documentation of services will be maintained and updated at least monthly by the curriculum of care facilitator. Records are confidential and may only be shared with participating team members unless informed consent is obtained from the child/youth's parent or guardian.

Necessary case record documentation for service eligibility must include:

- 1) A DCS referral form; and,
- 2) Documentation of regular contact with the referred families/children and referring agency; and,
- 3) Written monthly reports regarding each case facilitation that has been referred.

IX. Service Access

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

NOTE: All services must be pre-approved through a referral form from the referring DCS. In emergency situations, services may begin with a verbal approval

but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CHILD ADVOCACY CENTER**

I. Service Description

The Child Advocacy Center (CAC) facilitates a multidisciplinary team approach to the investigations of allegations of child abuse and neglect. Teams of professionals, include law enforcement, child protective services, prosecution, medical and mental health, victim assistance, and child advocacy. The CAC must be a designated legal entity responsible for program and fiscal operations. The CAC must be a child appropriate facility, which maintains focus on the child and helps to ensure that systems designed to protect children are able to do so effectively through culturally competent policies and practices. The purpose is to enhance the response to suspected child abuse cases by combining the expertise and professional knowledge of various investigative agencies and other professionals. Those involved in the CAC share a core philosophy that child abuse is a multifaceted community problem and that no single agency, individual or discipline has the necessary knowledge, skills or resources to serve the needs of children and their families.

The Child Advocacy Center **shall** provide the following:

Recorded interviews of child abuse victims in safe, child-friendly surroundings to avoid multiple interviews, reduce the trauma of disclosure, and preserve statements for court purposes. It consists of one or a series of developmentally appropriate, forensic interviews by a specially trained forensic interviewer who builds trust and rapport with the child while taking care not to suggest words or answers that are not the child's own. Other professionals may observe interviews and participate as appropriate by using a one-way glass window, bug-in-the-ear system or remote camera/television or some similar method of communication. Team discussion and information sharing regarding the investigation, case status and services needed by the child and family are to occur on a routine basis. The CAC must develop and implement a system for monitoring case progress and tracking case outcomes for team components.

The Child Advocacy Center **may** provide any or all of the following:

- Forensic medical exams, offered on-site or by a consulting physician, utilizing specialized equipment necessary for accurate diagnoses.
- Mental health professionals with special knowledge, skill and experience in this field provide therapy for child victims of abuse and their families. Services include individual, family and group therapy, crisis intervention, and consultation to the child's school.

- Play Therapy to allow children to work through worries and troubles and gain understanding and mastery of the world around them. This is a powerful means for children to overcome experiences of victimization and to acquire a sense of safety and appropriate personal power.
- Case review and tracking which includes follow-up calls to clients for up to two years to offer services and to assure that family conditions remain stable.
- Family Advocacy, crisis intervention, support/advocacy and counseling for victims and their families during the investigative and deposition process.
- Educational Programs
Free abuse awareness and prevention training to the community. Programs may include recognizing signs and symptoms of child abuse, methods for abuse prevention, body safety and the intricacies of the child protection system.
- Provide support groups for non-offending parents in cases of alleged child sexual abuse in a manner that they can act responsibly to protect and support the alleged child victim.

II. Target Population

Every child in Indiana alleging abuse may benefit from a multidisciplinary team approach to investigations in a safe, child friendly environment within a reasonable traveling distance.

Services must be restricted to the following eligibility categories:

- 1) Families and children for whom a child protection service investigation has been initiated.
- 2) Families and children for whom the children have been adjudicated a CHINS or have an Informal Adjustment

III. Goals

Goal #1

To provide a child and family friendly facility to which DCS and LEA may bring (or send) children and families for a forensic interview after a child's disclosure of abuse

Outcome Measures

- 1) Maintain a log of children interviewed
- 2) Maintain a log of MDT members using the facility
- 3] Maintain and/or provide multidisciplinary team members with a copy of the recorded interview according to established protocols

Goal #2

Provide a comprehensive multidisciplinary, developmentally and culturally appropriate responsive environment to prevent trauma to children during interviews.

Outcome Measures

- 1) Conduct interviews in the language of the child
- 2) Provide multidisciplinary partners appropriate training to ensure proper interviewing
- 3) Provide translators for child or family if one is necessary. This translator should be a non-family member of the client if possible.
- 4) Make provisions for hearing impaired child or family member if one is necessary. This translator should be a non-family member of the client if possible.

Goal #3

Maintain open communication, information sharing and case coordination with community professionals and agencies involved in child protection efforts.

Outcome Measures

- 1) Record interviews for sharing, as necessary, with community professionals (law enforcement, child protection services, prosecution, medical and mental health, victim assistance, and child advocacy) working with the child and non-offending family members.
- 2) Track interviews and services and coordinate with all professionals involved with the children and non-offending family members on an as needed basis.

Goal #4

Aid multidisciplinary team members educate non-offending caregivers on their role in the investigative process.

Outcome Measures

- 1) Help non-offending caregivers understand the legal and child protective systems
- 2) Assure non-offending caregivers understand their role is to support the child and not to gather facts independent of the multidisciplinary assessment/investigation.
- 3) Assist non-offending family members with regard to their lost of income or financial support, sudden change of lifestyle, and divided

Goal #5

Satisfaction with services

Outcome Measures

- 1) DCS satisfaction will be rated 4 and above on the Program Progress Report
- 2) 90 % of children reported feeling that the Child Advocacy Center was a child friendly/child appropriate facility.
- 3) 90 % of parents who filled out the evaluation reported satisfaction with the safety and positive or neutral effect on their child's anxiety.

IV. Qualifications

Minimum qualifications:

Centers minimally will have a director and support staff, as needed. In addition, centers may maintain a staff of trained volunteers who assist in the provision of Center program services under the supervision of Center staff.

- **Executive Director:** Bachelor's Degree or related experience preferred as required by center's board of directors.
- **Forensic Interviewer:** Bachelor's Degree in social work, psychology, criminal justice or a related field or a Master's Degree in Social Work or Forensic Science. A minimum of two (2) years of professional experience working with children and families where abuse and violence are identified issues is required. Requires previous professional experience in working with the criminal justice or child welfare system and as a member of a multi-disciplinary team.
- **Interns** must complete orientation training and will be supervised by the executive director.
- **Volunteers:** Must complete volunteer orientation training. Volunteers may be supervised by center staff.

V. Billable Rates

Interview rates will include all services that are provided as a part of the child forensic interview and assessment/investigation. All billed time must be associated with a family/client. Payment for services will be based on actual allowable costs. Grantees will bill monthly on these payment points: This cost may include:

- Forensic interview
- Family meeting with multidisciplinary team prior to and/or post interview
- Family advocacy
- Center staff time for case coordination and child supervision
- Case tracking
- Recording costs associated with the interview
- Team training
- Court preparation and testimony
- On- site medical examination as necessary
- Mental health counseling, play therapy

Billing records shall include the following information:

- Center case number
- Date of interview
- Names of child or children
- Name of parent/mother
- Name of DCS caseworker/s
- Name of interviewer

- Any other information required by the State

Translation or sign language

Services including translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client.

VI. Rates:

Interview Rate: _____

Translation or sign language rate: Actual Cost

Budget Summary must be submitted for rate determination.

VII. Service Access:

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

NOTE: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form. In emergency situations, services may begin with a verbal approval but must be followed by a written referral form within 5 days. It is the responsibility of the service provider to obtain the written referral.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CROSS-SYSTEM CARE COORDINATION**

I. Service Description

The provision of services is for youth with severe emotional disturbances and behavioral challenges that are involved in multiple care systems and are involved with the Department of Child Services and/or Juvenile Probation. Cross-system care coordination is designed to facilitate child and family teams comprised of youth, families, their natural support persons, local systems, agencies, and community members. These teams design individualized service and resource plans based on the needs of the youth.

Services in this system of care should be comprehensive, incorporating a broad range of services and supports, individualized, provided in the least restrictive, appropriate setting coordinated at the system and service delivery levels involve youth and families as full partners and emphasize early identification and intervention. Core values of a system of care are, that services are child centered and family driven, community based and culturally competent.

The services provided are comprehensive and will include cross-system coordination, case management, safety and crisis planning, comprehensive strength-based discovery and assessment, activities of daily living training, assistance to the FCM in the facilitation of the child and family team process, and family and child centered care. Support is provided and facilitated with community providers who can provide mentoring services, respite services, transportation services, community supervision, placement services, education services, therapies, social/recreational opportunities, specialized camps, independent living services, psychiatric services, psychological evaluations, medical needs services, parent support groups, mentoring and education, and medication management.

This service is based on the belief that children and their families are remarkably resilient and capable of positive development when provided with community-centered support, truly defined by what is in the best interest of the child. It is meant to provide a single comprehensive system of care that allows children in the child welfare and/or juvenile probation system(s) that experience emotional disturbances and their families to receive culturally competent, coordinated, and uninterrupted care.

The services provided to the clients and covered in the per child allotment rate will include but are not limited to the following:

1) Behavioral Health Services

- Behavior Management Services
- Crisis Intervention
- Day Treatment
- Evaluation / Testing Services

- Family Assessment
- Family Therapy
- Group Therapy
- Individual Therapy
- Parenting/ Family Skills Training Groups
- Special Therapy
- Substance Abuse Therapy- Group
- Substance Abuse Therapy- Individual
- Family Preservation – home based services

2) Mentor Services- hourly

- Case Management
- Clinical Mentor
- Educational Mentor
- Life Coach/ Independent Living Skills Mentor
- Parent and Family Mentor
- Recreational/Social Mentor
- Supported Work Environment
- Tutor

3) Other Services

- Consultation with Other Professionals
- Team Meetings
- Transportation

4) Psychiatric Services- hourly

- Assessments Outpatient
- Medication Follow-up/ Psychiatric Review

5) Respite Services

- Crisis Respite
- Planned Respite
- Respite-Residential or Hospital 23 Hour

6) Supervision Services

- Community Supervision
- Intensive Supervision

7) Residential Services

II. Specific Responsibilities

1.) The Care Coordinator has the specific responsibilities for the following:

- Evaluates and interprets referral packet information and completes a strength based assessment with child and family and the Child and Adolescent Needs and Strengths Assessment (CANS).
- Assist the Family Case Manager (FCM) in convening the family members, service providers and other child and family team members to form a collaborative plan of care with clearly defined goals.
- Addresses need for and develops, revises and monitors crisis plan with family and team members.
- Ensures that parent and family involvement is maintained throughout the service period.
- Maintains ongoing dialogue with the family and providers to assure that the philosophy of care is consistent and that there is progress toward service goals. Evaluates the progress and makes adjustments as necessary.
- Maintains central file consisting of treatment summaries, payment and resource utilization records, case notes, legal documents and releases of information.
- Facilitates the closing of the case and oversees transition to any ongoing care.
- Uses resources and available flex funding to assure that services are based specifically on the needs of the child and family.
- Able to deliver strength based, family centered, culturally competent services.
- Able to interpret psychiatric, psychological and other evaluation data, and use that information in the formation of a collaborative plan of care.
- Able to complete all documentation using a computerized clinical record.
- Creativity, flexibility and optimism about the strengths of children and their families.

2.) Providing agency receives referrals 24 hours a day, 7 days a week. There is a verbal determination between DCS and the agency that services are warranted, and there is agency availability for the service before the referral is sent.

3.) The face- to- face intake must occur no later than the end of the day following the referral.

4.) Assessments including the goal setting and service plan are mutually established between the client, ~~and~~ care coordinator with a written report signed by the family and care coordinator, submitted to the DCS referring worker within 7 days of the initial face-to-face intake. Communication between the care coordinator and DCS is constant and documented as arranged between the two.

5.) Each family receives access to services through a single care coordinator acting within a team, with availability 24 hours a day 7 days a week.

6.) Family functioning assessments, family's response, presenting problems according to DCS referral are factors included in the goal setting. Goals are behaviorally specific, measured and attainable.

7.) Safety is of paramount importance. If there are indications about safety concerns within the home there is an obligation for the care coordinator and DCS to communicate to address all safety concerns, and document safety steps taken to resolve the issues. If new incidences occur, the care coordinator is to notify DCS immediately of the situation.

8.) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement.

III. Target Population

Services must be restricted to cases where severe emotional disturbances and/or behavioral problems have been documented within the following eligibility categories:

- 2) Children and families with a case type of Informal Adjustment (IA) with moderate to high levels of risk and service needs according to the DCS assessment matrix; and,
2. Children with a status of CHINS, and/or JD/JS (Juvenile Delinquency/Juvenile Status); or,
3. All adopted children and adoptive families

IV. Goals and Outcome Measures

Goal #1: Provide high quality care which results in improved outcomes for the child and family.

Improved child and family functioning

A.) Improved school functioning

- An increase in scores as found on grade reports in 85% of cases
- Decrease in absenteeism/truancy as reflected by attendance reports in 85% of cases
- A decrease in behavior reports in 85% of cases
- A decrease in suspension/expulsion reports in 85% of cases
- The Care Coordinator Treatment Plan level rating decreases in severity in 85% of cases

B.) Improved records with the child welfare and juvenile justice system

- 85% of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home during involvement
- 85% of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home for a period of six and twelve months from disenrollment

- 85% of children with no further substantiated incidences of delinquency, runaway or truancy charges, or violation of terms of probation which results in placement failure during enrollment
- 85% of children with no further incidences of delinquency, runaway or truancy charges, or violation of terms of probation which results in placement failure for a period of six and twelve months from disenrollment.

C.) Improved CANS scores

- 50 % of the children and families will have statistically significant improvement in any life domain on the CANS (functioning, behavioral health systems, risks, caretaker needs and strengths, chld's strengths)

D.) Progress in Service Coordination Plan

- Measured by monthly team report and Care Coordinator Treatment Plan
- Level rating in 100% of cases

Increased family autonomy

A.) Decrease in number of paid providers

- Measured by service usage and payment data in 100% of cases

B.) Caregiver Strain Questionnaire

- Decrease in Caregiver Strain measured by Questionnaire at intake, every 6 months until discharge and 12 months after discharge in 100% of cases

V. Qualifications

Supervisor

1. Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related Human Services field; and,
2. A current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following:
 - Clinical Social Worker
 - Marriage and Family Therapist
 - Mental Health Counselor

Care Coordinator

1. Bachelor's Degree in Social Work or related Human Service field; and,
2. Minimum of three years of clinical/management experience in human service field; and,
3. Demonstrated 2 or more years of clinical intervention skills; and,
4. Demonstrated skill in fiscal management activities, team building and development Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

The Care Coordinator assures care is delivered in a manner consistent with strength-based, family centered, and culturally competent values, offers consultation and education to all providers regarding the values of the model, monitors progress toward treatment goals and assures that all necessary data for evaluation is gathered and recorded.

VI. Billable Units

Billable units will be based on four levels of service and are based on intensity with Level 1 being the least intense and Level 4 with the most intense. **Attach to your program narrative the definition of your levels of service of intensity and their components.** The assessment period will help determine the appropriate tier based on CANS scores, other criteria, and collateral information. Billable rates will include all costs associated with services and placement.

Due to economies of scale, the cost associated with serving each youth decreases as the number of youth served increases. As a result, the case rates vary based on the number of youth enrolled and the level of service. Rate will be defined as a monthly rate and daily rate based on the other criteria.

*Note that Medicaid MRO is used to pay for care coordination and some services when possible.

VII. Rates

Per Youth per Month

Levels	150 Youth	225 Youth	300 Youth
1	\$1,565	\$1,493	\$1,421
2	\$2,780	\$2,708	\$2,636
3	\$4,290	\$4,215	\$4,146
4	\$6,500	\$6,428	\$6,356

Per Youth per Day

Levels	150 Youth	225 Youth	300 Youth
1	\$51.45	\$49.08	\$46.72
2	\$91.40	\$89.03	\$86.66
3	\$141.04	\$138.67	\$136.31
4	\$213.70	\$211.33	\$208.96

If the number of youths to be served and the cost associated are different from above then a budget summary must be submitted.

VIII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1.) A completed, signed and dated DCS referral form authorizing service.
- 2.) Documentation of regular contact with the referred families/children
- 3.) Written reports as requested. Formats for written reports and forms will be collaboratively designed for use.

IX. Service Access

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a new reauthorization for services to continue beyond the approved time period.

NOTE: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DOMESTIC VIOLENCE INTERVENTION SERVICES**

I. Service Description

Domestic Violence services are comprehensive and service delivery is expected to include the batterer, survivor and child. The provider may accomplish this through subcontracting and the provider is responsible for the reporting and coordinating of services to all 3 populations. Domestic Violence intervention services shall not exist in isolation, as it is only one component of a coordinated community response to domestic violence. Services shall maintain cooperative working relationships with local programs (domestic violence batterer programs, survivor programs, shelters, law enforcement, advocates, legal services, etc.) Services shall be structured, goal-oriented and time-limited individual/group therapy and casework services.

Group is the preferred treatment modality for the batterer. However, access to individual treatment services is available. The Exclusion Criteria section provides guidelines for exceptions to this treatment modality. Also, communication is vital between the provider of the batterer treatment and the victim, given the propensity of batterers to present well in group but continue to abuse.

Definition of Domestic Violence

(ICADV Definition) A pattern of assaultive or coercive behavior, including physical, sexual, or psychological attacks, as well as economic coercion, that adults or adolescents use against an intimate partner. Intimate partners include spouse, former spouse, those living or having lived as if a spouse, those having a child in common, those having a past or current sexual relationship, or a past or current dating relationship.

**Definition from the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

Child safety and ending violence takes precedence over saving relationships. The treatment focus shall be: child safety, survivor safety, increasing the survivor and child's functioning emotionally and regarding life skills, batterer accountability, providing the batterer skills to change abusive behavior, and ending physical, sexual and psychological violence.

The provider shall establish a written policy requiring that all staff have a duty to warn and protect survivors, partners, children and others against whom the batterer has made a threat of violence. This policy will detail the criteria for determining when a duty to warn arises, and the procedures staff are expected to follow.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals).

The provider must be available to respond for crisis intervention as needed.

Services will be provided within the context of the Department of Child Services' practice model with involvement in Child and Family team meetings if invited. A treatment plan will be developed and based on the agreements reached in the clinical assessment and the Child and Family Team Meeting. Separate treatment plans will be developed for the batterer, survivor and the child.

Services must be available to participants who have limited daytime availability. The provider must identify a plan to engage the participant in the process, and a plan to work with non-cooperative participants including those who believe they have no problems to address.

Provider must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the contract.

Service Description includes Batterer Treatment, Survivor Treatment, Child Treatment, Batterer Remaining in the Home, Support Groups and Interventions to Exclude from Treatment:

A. Batterer Treatment

Collaboration

Batterer treatment must work in collaboration with local programs that serve survivors of domestic violence, law enforcement, the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV) and others. Collaboration shall include:

- Measuring effectiveness of the treatment by treatment outcome measures
- Being an active participant in local coordinated community response efforts

**Adapted from the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

Assessment

Within 24 hours after initiation of services, batterers will receive an initial assessment of needs when DCS indicates imminent risk/immediate safety concerns, or no later than 48 hours. Assessments shall include but are not limited to:

- Batterer's past and current use of physical and sexual violence, including other abusive behaviors, within and outside of intimate relationships
- History of violence within family of origin
- History of use, possession of, or access to weapons
- Lethality risk assessment
- Criminal history
- Pending court actions
- Current or former partners
- Threats of taking the child

- Access to the survivor
- Substance abuse assessment
- History of mental illness, including threats or ideations of homicide
- Learning disabilities, literacy and special language needs

Exclusion Criteria

Individuals who are found through the assessment to be unable to benefit from group services must be provided other appropriate services. Individuals to be excluded are those who are a threat to the safety of group participants as they are likely to be seriously violent or disruptive, those with psychiatric symptoms or serious developmental delays preventing participation or those with a medical condition that is the primary cause of violence, such as brain injury. Excluded individuals may enter the program at a later date in the event the reasons for exclusion have been alleviated.

Treatment Plans

Comprehensive treatment plans will be developed based on the assessment and will contain both long-term and short-term goals. Plans at a minimum will:

- Reflect underlying needs and goals
- Build on realistic possibilities and options
- Emphasize batterer accountability for violence
- Respond to the needs of their child(ren)
- Help the batterer recognize the impact of domestic violence on the child
- Assist the batterer in creating a safe, nurturing and stable environment for the child long-term that includes the use of formal and informal supports.
- Be tailored to the batterer's strengths, needs, risks, available resources and unique circumstances
- Skills to assist the batterer in interacting with the survivor on issues dealing with the best interest of the child, in circumstances where face to face contact is necessary (visitations, school/athletic events etc.)

An aftercare plan will be developed identifying and promoting the continued use of informal and community supports, increasing the likelihood that services will be accessed after case closing.

Participant Agreement

Batterers shall sign a contract including but not limited to, the following:

- I will not abuse anyone else or myself for duration of program. This includes verbal, emotional and psychological abuse, threats of suicide, and threats of violence. I will inform the provider of what happened and I will openly talk about the situation and accept responsibility for my behavior.
- I agree that the reason I am in batterer treatment is to learn to not be violent or abusive. I will not be violent or abusive in this group or in my personal life.

- I will participate openly, honestly and actively in group discussions and will follow through with all group assignments.
- I will abide by all group rules, including attendance.
- I will seek appropriate treatment if additional problems arise (e.g. drug abuse, mental health issues), and I will cooperate with if the group facilitator requests that I obtain an assessment for any of these problems.
- I will provide the correct address and phone number of the survivor and will notify the group facilitator of any changes. I give the group facilitator and other individuals working with him/her permission to give out the following information to the survivor: 1) When I start and stop the program, 2) Referral information to counseling services, and 3) safety options, and any other information pertinent to safety.
- I understand that I may not be informed of any communication that takes place between the survivor and the group facilitator and I waive any right to have access to or be informed of the nature, content or existence of any such communication.
- I understand that safety to others and to myself is priority and will be enforced by the group facilitator.
- I understand that all suspected child abuse and neglect will be reported as defined by Indiana law.
- I understand that all suspected battery, neglect or exploitation of an endangered adult will be reported as required by Indiana law.
- I have received and understand the service provider's policies and procedures.

Exceptions to Confidentiality

Batterers shall sign a written waiver of confidentiality at the time of intake. The waiver may include an end date, but an exception must be included in the text of the waiver that extends the waiver beyond the end date where necessary. This is to prevent the participant from avoiding legal consequences for criminal or violent acts or in order for the provider to respond to a court subpoena for information or testimony. The waiver shall give the service provider permission to:

- Make reports
- To testify
- To otherwise communicate as needed
- To reveal file and other information regarding the batterer to each of the following:
 - DCS, as the referral source
 - The court, lawyers, prosecutor, police, probation
 - The survivor or designated advocate
 - Administrative and professional personnel who need information for record-keeping, monitoring, or professional development
 - Any entity or person to whom the service provider is legally bound to report suspected abuse or neglect of a child

- Any person whose safety appears to be at risk due to the participant's potential for violence and lethality, in order for the service provider to fulfill its duty to warn or protect

Curriculum Content

The central focus of curriculum will remain on batterer responsibility and accountability for their beliefs and actions. It will actively challenge all abusive behaviors and survivor blaming. Curriculum delivery should be designed to accommodate new participants in an ongoing group and to ensure no participant misses curriculum content. Curriculum shall reflect an awareness of cultural diversity. Curriculum used or developed by service providers will include but is not limited to, the following:

- Definition of domestic violence.
- Forms of abuse, including:
 - physical, sexual, emotional
 - economic manipulation or domination
 - property destruction
 - stalking
 - terroristic threat
 - acts jeopardizing the well-being and safety of partners, children, pets, other family members and friends
- The dynamics and tactics of power and control, and the cycle of violence.
- Relationship between substance abuse, mental illness and acts of violence, with a distinction that there is not a cause and effect relationship.
- Gender roles; beliefs in male entitlement and male privilege and rigid sex-role stereotypes.
- Identifying and challenging cultural and social influences that promote, sustain or excuse abusive behavior.
- Batterer's responsibility for past and future abusive behaviors and the need to avoid survivor blaming.
- Current Indiana state law and practice regarding domestic violence.
- Adverse legal and social consequences for batterers.
- Identifying and challenging the batterer's personal values and beliefs that promote, sustain or excuse abusive behavior.
- Participant will identify, confront, and change abusive and controlling behaviors.
- Long-term and short-term effects of abuse on the survivor and on children who are witnesses and/or survivors.
- Empathy for the survivor and child's experience.
- Equality and power-sharing in relationships
- Cooperative and non-abusive forms of communication and conflict resolution
- Non-violent alternatives and techniques for achieving non-abusive and non-controlling conduct.

- Nonviolence planning; identification of danger signs violence may occur and how to prevent them
- Relapse prevention plan that provides alternatives to all forms of abuse and includes input from the batterer.
- Skills to assist the batterer in interacting with the survivor on issues dealing with the best interest of the child, in circumstances where face to face contact is necessary (visitations, school/athletic events etc.)

Treatment Modality

Group treatment for adult batterers of the same gender. Group is without survivor participation. Twenty-six (26) sessions 1.5 hours in length. Class size minimum of 7 and is not to exceed 20 participants. A waiver can be requested when less than 7 participants attend the training. A written request of waiver is sent to the Director or his designee at the Department of Child Services local office for approval.

Criteria for Satisfactory Completion

The service provider will provide criteria in writing for satisfactory completion of treatment. At a minimum the provider will include the following criteria for completion of treatment:

- Attendance at weekly group sessions and all other required treatment periods
 - Attendance shall be recorded by the group facilitator.
 - Three (3) unexcused absences are permitted. In the event any absences are consecutive or 4 classes total classes are missed, the batterer shall be dismissed from treatment.
 - The batterer shall be on time for each group session. If the batterer leaves class he/she may not return and shall be counted absent.
- Cooperation of program rules and conditions throughout treatment services
 - Failure to comply with rules and conditions shall be documented. Non-compliance more than 3 times shall result in expulsion from the group.
- Cessation of violence and other abusive and controlling conduct while a participant in the program
- Adherence to the participant's agreement
 - Failure to comply with the participant agreement shall be documented. Non-compliance more than 3 times shall result in expulsion from the group.
- Compliance with court orders
- Accepting responsibility for abusive and controlling behavior and ceasing to blame the survivor
 - As evidenced by an assessment of the batterer
- Recognition of the adverse effects of their abusive and controlling behavior

- As evidenced by an assessment of the batterer

Note: The batterer may pursue other treatment methods after satisfactory completion of group treatment. The batterer should only be included in marital/couples or family therapy if the batterer has done extensive work to change violent behavior and there is proof of progress. The batterer should not be included in marital/couples or family therapy if there is reason to be concerned about the survivor/child's safety or wellbeing.

Expulsion from Program

The service provider will develop guidelines in writing for expulsion so that decisions are uniform and predictable and so that discrimination does not occur against participants based on race, class, age, physical handicap, religion, educational level, ethnicity, national origin, sexual orientation or gender. The provider will immediately notify DCS of the expulsion of any batterer.

Guidelines shall include, but are not limited to:

- Continued or renewed physical or sexual assaults, threats, stalking or repeated or severe psychological abuse
- Threats or violence to program staff or group participants
- Bringing weapons or illegal substances to program property
- Failure to comply with the attendance policy, group rules or other program rules and conditions
- Failure to comply with the participant agreement
- Violation of any judicial orders pertaining to violence, the safety of the survivor and/or children or the intervention process

Non-compliance with the agreement, court orders or with group rules will be documented in writing.

Note: Batterers may be re-enrolled in group on an individual basis at the provider's discretion in consultation with the referring FCM. .

The Appropriate Use of Provider Contacts with the Survivor in the Context of Batterer Treatment

The provider performing survivor contact will have observed a minimum of 26 batterer treatment sessions and the observation of sessions must be conducted so as to include an entire curriculum. The purpose of contact with the survivor shall be limited to the following:

- Informing the survivor of the batterer's entry in, removal or completion of group treatment.
- Outlining group content and treatment procedures.
- Answering any questions about the treatment program and clarify any misinformation that may have been given.

- Inviting the survivor to make future contact with any information, questions, concerns or reports of violence and re-offenses or violations of the participant contract/agreement that may arise.
- To ascertain survivor safety.
- To follow up on suspected participant re-offense.
- Encouraging the survivor to utilize the availability of domestic violence outreach, advocacy, emergency shelter services or to attend support groups or orientations for survivors.
- Sharing provider concerns/evaluations/observations of the batterer's in group participation. Caution the survivor to not assume the batterer's good conduct or completion of the treatment program is a predictor of future positive change or nonviolent choices.
- Discussing safety planning.
- Warning the survivor of any threats of violence made by the batterer or provider reason to believe there is an unacceptable risk of violence.

Protocol for Contacts with the Survivor in the Context of Batterer Treatment

Contact with the survivor should only be made by a trained victim advocate who is not providing direct services to the batterer.

The service provider will establish and follow written rules regarding the method of survivor contact. Contact refers to any mail, phone, e-mail, or face-to-face contact, direct or indirect, with any survivor of any batterer participating in group treatment *before, during or after the batterer's enrollment in group*.

Contact rules shall include but are not limited to the following:

- Take steps to ensure that mail, telephone and other communication is as secure as possible against intrusion by the batterer or others.
- Inform the survivor of her/his right to confidentiality and ability to consent to disclosure of her/his report. Caution the survivor to consent to disclosure only if she/he has a safety plan and believes disclosure will not reduce her/his safety.
- Inform the survivor prior to inviting them to share information, that any information regarding suspected child abuse cannot be confidential and must be reported to the legal system.
- Inform the survivor that neither the provider staff nor the legal system can guarantee their safety, and neither can they guarantee that disclosure of their report will not result in a violent reaction by the batterer.
- Inform the survivor that a witness statement or complaint to the legal system cannot be made confidentially or anonymously, yet they may receive help in determining the timing and method by which the batterer is confronted.
 - Reporting statements made by the survivor to the legal system is equivalent to confronting the batterer. When by law the provider

must report an incident without survivor consent, the survivor will be allowed time for safety planning.

- Document in writing the survivor's consent or lack thereof, as well as the survivor's wishes regarding the use of any information they have given.
- Assume the survivor has denied consent to disclose their report to anyone, including the group facilitator, unless they have specifically stated otherwise and disclosure wishes are documented in writing.
- The batterer shall not be confronted regarding information from the survivor when the service provider in consultation with victim advocates have reason to believe confrontation will create an unacceptable risk of retaliation abuse.
- Do not pressure or convince the survivor to make a report or agree to the disclosure of information or confrontation of the batterer, or to agree to make a report or take any action that they may feel is not in their best interests.
- Assume the survivor may accurately or inaccurately relay to the batterer what was said by provider staff during survivor contact.
- Do not offer the survivor therapy, counseling, communication, mediation or reunification with the batterer participating in group treatment.

Program Monitoring

The provider will establish a written working agreement with a local independent domestic violence program or advocate. The local domestic violence program or advocate will be referred to as the "monitor". This written agreement shall include:

1. Identification of the persons responsible for implementation from both organizations.
2. A system for conflict resolution in the event it is needed.
3. The following criteria to guide monitors in the evaluation of programs and direct services:
 - a. Does the program promote the cessation of domestic violence and the overall safety and empowerment of victims of domestic violence?
 - b. Is the program accountable and responsive to the survivor? In particular, does the program protect the survivor's safety, confidentiality, and right to information?
 - c. Is the program accountable and responsive to local domestic violence advocates?
4. A statement that monitors may not in any way provide direct service to the program participants.
5. A commitment that the program will involve the monitors in the process of establishing program principles, policies, and procedures at an early stage where the monitors' input will affect the results.
6. A commitment that the program will involve the monitors whenever policies and procedures are being reviewed and changed.

7. A commitment that the program will consult with monitors in the recruitment, selection, and training of staff, and value monitors' concerns about ongoing staff behavior and performance.
8. A protocol that details how the program will record program sessions, or provide other meaningful ways that monitors can observe or listen to direct services being provided. The protocol for monitoring of groups will include:
 - a. The frequency of monitoring with a minimum of one time per quarter per facilitator.
 - b. A statement that the monitor is recording/evaluating the effect of staff facilitation on survivor safety and batterer accountability, not evaluating participants, and is obligated to honor participant confidentiality.
 - c. The criteria for group monitoring.
 - d. A directive that monitors return all recordings and forms to program administrator for confidential filing, that group tapes may be erased, but monitoring forms are kept for three years.
9. A statement that the program will collaborate with the monitors in community-wide strategies to end domestic violence.
10. A format and timetable for regular feedback to the program, for follow-up on feedback, and for a formal, annual evaluation. This feedback and evaluation will cover all aspects of monitoring, including program development, staffing, direct services and collaboration in the community-wide DV response.

**Adapted from the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

B. Survivor Treatment

Assessment

Within 24 hours after initiation of services, survivors will receive an initial assessment of needs when DCS indicates imminent risk/immediate safety concerns, or no later than 48 hours. Assessments shall include but are not limited to:

- Safety and risk factors for the survivor and their child(ren)
- Medical/dental care
- Legal assistance
- Food/shelter/clothing
- Parenting needs and the parent/child relationship
- Screening for other co-occurring issues (substance abuse, mental health issues, etc.)

Safety Plans

Comprehensive safety plans will be developed based on the assessment and will contain both long-term and short-term plans. Plans at a minimum will:

- Prepare the parent to promote their safety in various circumstances, including those calling for emergency re-location
- Plan how the parent will create a safe, nurturing and stable environment for the child

Treatment Plans

Comprehensive treatment plans will be developed based on the assessment and will contain both long-term and short-term goals. Plans at a minimum will:

- Reflect underlying needs and goals
- Build on realistic possibilities and options
- Emphasize that the violence is not the survivor's fault
- Respond to the needs of their child(ren)
- Help the parent recognize the impact of domestic violence on the child
- Assist the survivor in creating a safe, nurturing and stable environment for the child long-term that includes the use of formal and informal supports.
- Be tailored to the survivor's strengths, needs, risks, available resources and unique circumstances
- Skills to assist the survivor in interacting with the batterer on issues dealing with the best interest of the child, in circumstances where face to face contact is necessary (visitations, school/athletic events etc.)

An aftercare plan will be developed identifying and promoting the continued use of informal and community supports, increasing the likelihood that services will be accessed after case closing.

Advocacy and Support Services

Supportive services shall be provided as needed and as consistent with the assessment and treatment plan. Services shall emphasize personal growth, development, situational change and helping to gain confidence in personal abilities. Services shall include but are not limited to:

- Housing assistance and housing readiness
- Management of legal needs
- Employment education and preparedness
- Educational resources
- Linking to community resources

Treatment Modality

Treatment should be provided in the method consistent with the assessment and treatment plan and may occur through individual and/or family therapy, marital/couples therapy, support groups and casework services.

Group treatment is for survivors of the same gender and occurs in twenty-six (26) sessions 1.5 hours in length. Class size minimum of 7 and is not to exceed 20 participants. A waiver can be requested when less than 7 participants attend the training. A written request of waiver is sent to the Director or his designee at the Department of Child Services local office for approval.

Therapeutic Group Curriculum Content

Group curriculum shall include but is not limited to, the following topics:

- Explore the survivor's attitudes and beliefs about families and family violence
- Explore self concept and boost self-esteem
- Emphasizing violence is not the survivor's fault
- Teach the cycle of domestic violence
- Teach the impact of violence on their child's development
- Build parenting competence
- Provide a safe place to discuss parenting fears and worries
- Enhance parenting and disciplinary skills
- Enhance social and emotional adjustment
- Skills to assist the survivor in interacting with the batterer on issues dealing with the best interest of the child, in circumstances where face to face contact is necessary (visitations, school/athletic events etc.)

C. Child Treatment

Assessment

Within 24 hours after initiation of services, children will receive an initial assessment of needs when DCS indicates imminent risk/immediate safety concerns, or no later than 48 hours. Assessments shall include but are not limited to:

- Safety and risk factors for the child
- Child abuse/neglect
- Medical/dental care
- Food/shelter/clothing
- The parent/child relationship
- Screening for other co-occurring issues (substance abuse, mental health issues, behavioral issues, social impairment, educational impairment, etc.)

Safety Plans

(Note: the child must be willing and able to use the plan, and have the ability to opt out of any step in the plan if needed)

Comprehensive safety plans that are age and developmentally appropriate will be developed based on the assessment will contain both long-term and short-term plans. Plans at a minimum will:

- Include input from the non-abusive parent and be age appropriate
- Include input from the child when appropriate
- Identify safe places to go inside/outside of the home during violence
- Identify where to meet if exiting the home is necessary
- Identify how and when to use the phone for help
- Identify what to do/not to do during an argument/violence

Treatment Plans

Comprehensive treatment plans will be developed based on the assessment will contain both long-term and short-term goals. Plans at a minimum will:

- Reflect underlying needs and goals

- Build on realistic possibilities and options
- Promote positive behavior patterns and positive self image
- Emphasize that the violence is not the child's fault and violence is not the fault of the survivor
- Teach strategies for managing and reducing symptoms experienced in response to domestic violence
- Critical thinking skills to enhance the child's ability to identify the batterer's controlling behaviors
- Be tailored to the child's strengths, needs, risks, available resources and unique circumstances

Advocacy and Support Services

Supportive services shall be provided as needed and as consistent with the assessment and treatment plan. Services shall emphasize personal growth and development. Services shall include but are not limited to:

- Educational/developmental resources
- Links to community resources

Treatment Modality

Treatment should be provided in the method consistent with the assessment and treatment plan and may occur through individual or group therapy, play therapy or group play therapy, family therapy, support groups and casework services.

Group treatment for children is to occur in 26 weekly sessions 1.5 hours in length. Class size minimum of 7 and is not to exceed 20 participants. A waiver can be requested when less than 7 participants attend the training. A written request of waiver is sent to the Director or his designee at the Department of Child Services local office for approval.

Therapeutic Group Curriculum Content

Group curriculum will be age appropriate and shall include but is not limited to, the following:

- Promote open discussion of experiences with violence for integration into the child's understanding
- Help the child understand why their caregivers fight
- Violence is not the child's fault and violence is not the fault of the survivor
- Help the child understand and cope with their emotional responses to domestic violence
- Teach identification and labeling of feelings to help the child express his or herself.
- Explore the child's attitudes and beliefs about families and family violence
- Teach how to effectively manage anger
- Explore self concept and boost self-esteem
- Teach the cycle of domestic violence

- Critical thinking skills to enhance the child's ability to identify the batterer's controlling behaviors

D. Batterer Remaining in the Home

Service standards regarding the *assessment, treatment planning and treatment modality* will remain the same as prescribed above for the batterer, survivor and child when the batterer lives in the same home as the survivor and child.

The following standards regarding safety planning will be used:

Batterer

Comprehensive safety plans will be developed based on the assessment and will contain both long-term and short-term plans. Plans at a minimum will:

- Plan how the batterer will create a safe, nurturing and stable environment for the child
- Identify the batterer's triggers as warning signs and include nonviolent alternatives
- Require participation in batterer's intervention treatment
- Address the violence as a choice of the batterer.

Survivor

Comprehensive safety plans will be developed based on the assessment and will contain both long-term and short-term plans. Plans at a minimum will:

- Prepare the survivor to promote their safety in various circumstances
- Plan how the survivor will create a safe, nurturing and stable environment for the child
- Identify the batterer's triggers as warning signs and identify what to say/not to say during an argument
- Identify safe areas of the house with exits to use when violence is threatened
- An escape plan for use if needed, which may include:
 - A transportation plan
 - Pre-packed luggage in a safe place inside or outside of home
 - Access to hidden money, check books or savings books, even if in small amounts
 - Access to legal documents such as a driver's license, birth certificates, social security cards
- Family/friends code word or emergency signal

Child

(Note: the child must be willing and able to use the plan, and have the ability to opt out of any step in the plan if needed)

Comprehensive safety plans that are age and developmentally appropriate and will be developed based on the assessment will contain both long-term and short-term plans. Plans at a minimum will:

- Include input from the non-abusive parent and be age appropriate
- Include input from the child when appropriate
- Identify safe places to go inside/outside of the home during violence
- Where to meet if exiting the home is necessary
- How and when to use the phone for help
- What to do/not to do during an argument/violence
- Family/friends code word or emergency signal
- Boundaries regarding what not to tell the batterer

E. Support Groups

The provider shall offer a support group for survivors and children. The group facilitator shall be a Caseworker. Survivor groups shall be held separately from Child groups. Child groups should be age appropriate. The purpose of the group is for members to provide each other with various types of help, usually nonprofessional and nonmaterial, for a particular shared, usually burdensome, characteristic. The help may take the form of providing and evaluating relevant information, relating personal experiences, listening to and accepting others' experiences, providing sympathetic understanding and establishing social networks. Groups should increase self-esteem, teach healthy ways to express feelings and resolve conflicts and provide tools to form healthy relationships.

F. Interventions to EXCLUDE from treatment:

(Note: the following interventions are to be excluded in all situations, including when the batterer lives in the same home as the survivor and child)

- Group treatment that involves mixed gendered participants.
- Interventions that blame the survivor or consider violence as a mutually circular process.
- Interventions that rely on or coerce survivor/child participation or communication.
- Interventions that identify poor impulse control or psychopathology as the primary cause of violence.
- The batterer should only be included in the treatment of the survivor/child if the batterer has done extensive work to change violent behavior. The batterer should not be included in the treatment of the survivor/child if there is reason to be concerned about the survivor/child's safety.
- Ventilation techniques and other treatments that encourage the expression of rage, such as punching pillows and primal screams.
- Batterer treatment should not be substituted with substance abuse, addictions, anger management and/or mental illness counseling. Group treatment should be completed before the batterer becomes involved in other treatment programs, *except* when the batterer has been assessed with a chronic substance abuse or mental health problem that warrants intervention and this treatment shall be kept separate from group batterer treatment.
- Individual counseling for the batterer is not an appropriate intervention *except when the batterer meets exclusion criteria and cannot benefit from group services.*

- Group treatment of children who have been severely traumatized, regardless of age. These children have more complex needs and are better served by individual treatment.
- Interventions that encourage the provider to become an advocate or witness on behalf of the batterer or further the interests of the batterer in legal matters.
- Negotiating or mediating for the batterer with the survivor in any way.

I. Target Population

Services must be restricted to cases where domestic violence has been documented within the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the DCS assessment matrix; where reunification is jeopardized without intervention of intensive services, and
- 2) Children with a status of CHINS, and/or JD/JS, or
- 3) All adopted children and adoptive families.

II. Goals and Outcome Measures

Goal #1: DCS and family satisfaction with services

Outcome Measure: 90 % of the families who have participated in Domestic Violence Services will rate the services “satisfactory” or above.

Outcome Measure: DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

Goal #2 Timely intervention with family where DCS indicates imminent risk/immediate safety concerns, and regular and timely communication with referring worker

Outcome Measure: 100 % of families receive their first face to face visit no later than the end of the first day following the referral from DCS.

Outcome Measure: 100 % of written treatment plans/ assessments will be completed, and sent to the referring worker within 7 days of face-to-face intake with the client/family.

Goal #2: survivor/child improved safety and safety skills

Outcome Measure: The provider will document ongoing assessments that the survivor and child’s physical safety is assured.

Outcome Measure: 100 % of victims know how to plan for their continued safety.

Outcome Measure: 95 % of victims report their safety has improved.

Outcome Measure: 95 % of victims report having an increased understanding of their legal rights.

Outcome Measure: 90 % of victims report they know how to access short and long-term resources that meet their emotional and safety needs.

Outcome Measure: 95 % of victims report an increased knowledge of services available.

Goal #3: Improved functioning/decrease in symptoms associated with DV

Outcome Measure: 100 % of victims report an increased knowledge and understanding of domestic violence and its effect on their children.

Outcome Measure: 90 % of children report an understanding and ability to cope with their emotional responses to domestic violence.

Outcome Measure: Improved family functioning as indicated by no further incidence of the presenting problem in 98 % of the families.

Outcome Measure: 75 % of survivors report a Reduction of Fear, Improved psycho-social functioning, and reduction of traumatic stress symptoms.

Outcome Measure: 90 % of children report an increase in self esteem, positive behavior patterns, and self concept.

Goal # 4: Documentation, completion, and conception of Batterer treatment

Outcome Measure: 100 % of no-show alerts will be provided to referring worker

Outcome Measure: 100 % of referred clients will have a treatment plan developed following the assessment with the treatment plan provided to the referring worker within 10 days of completion.

Outcome Measure: 100 % Cessation of violence after three months and six months on completion of the Batterer Intervention Program.

Outcome Measure: 75 % intervention increases client's egalitarian partnerships, positive behaviors, social skill, pro-social antiviolence attitudes, and psychological and social functioning

Outcome Measure: 80 % Intervention reduces and prevents further injury to the victim, re-arrest or other types of official recidivism, physical abuse, psychological maltreatment, sexual abuse, separation abuse, violence supporting attitudes, and beliefs held by the batterer about domestic violence.

III. Qualifications

Note: there will be no discrimination of race, class, age, religion, ethnicity, national origin, sexual orientation or handicaps in hiring of employees or in providing services to batterers.

Therapist:

Master's degree in social work, psychology, marriage and family or a related human services field. Knowledge of current Indiana state law and practice regarding domestic violence. Minimum 2 years professional field experience in family violence treatment with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following:

- 1) Clinical Social Worker
- 2) Marriage and Family Therapist
- 3) Mental Health Counselor

Educational and Training Requirements for Providers of Batterer Treatment:

- 1. Co-Facilitator:** To qualify to co-facilitate a batterer program with a qualified program Supervisor/Trainer or Facilitator, an individual must show:
 - a. Evidence of 60 hours of formal training. A minimum of 40 hours of this training must be specific to domestic violence. The remaining 20 hours shall include evidence of training in each of the following areas of group facilitation skills: cultural diversity, substance abuse, and mental health.
 - b. Evidence of observing a minimum of 26 different batterer program sessions.
 - c. The observation of sessions must be conducted so as to include an entire 26 session curriculum.
- 2. Facilitator:** To qualify to facilitate a batterer program an individual must show:
 - a. Evidence of meeting all the requirements of a Co-facilitator.
 - b. 100 hours of formal training. A minimum of 60 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills: cultural diversity, substance abuse, and mental health.
 - c. Evidence of co-facilitating a minimum of 26 additional batterer program sessions with a Supervisor/Trainer.
- 3. Supervisor:** To qualify to supervise a batterer program, an individual must show:
 - a. Evidence of meeting all the requirements of a Facilitator.
 - b. 120 hours of formal training. A minimum of 80 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills: cultural diversity, substance abuse, and mental health.

- c. Evidence of facilitating a minimum of 26 additional batterer program sessions as a Facilitator under a Supervisor/Trainer.

4. Trainer: To qualify to train staff or others related to batterer program work, an individual must show:

- a. Evidence of fulfilling the requirements of a Supervisor.
- b. Have a minimum of 3 years experience as a supervisor (or the equivalent thereof).

**Adapted from the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

Continuing Education for Providers of Batterer Treatment:

Individuals must show evidence of participating in a minimum of 10 hours of formal continuing education specific to domestic violence annually to maintain their status as a qualified service provider.

**From the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

Caseworker:

Casework services may be provided as needed by personnel with a Bachelor's degree in social work, psychology, sociology, or a directly related human services field.

Knowledge of current Indiana state law and practice regarding domestic violence.

Minimum 2 years professional field experience working with family violence.

Supervisor:

Master's degree in social work, psychology, marriage and family or a related human services field. Knowledge of current Indiana state law and practice regarding domestic violence. Minimum 2 years professional field experience working with family violence with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following:

- 1) Clinical Social Worker
- 2) Marriage and Family Therapist
- 3) Mental Health Counselor

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks. Regarding group treatment the supervisor will attend and observe a full batterer's group session within 30 days of the first group meeting and every 30 days, unless attendance is requested more frequently.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

Worker qualities:

Personnel have the competencies and support needed to:

Department of Child Services
Regional Document for Child Welfare Services
Term 1/1/09 to 6/30/11

- Engage, empower and communicate effectively, respectfully and empathetically with families from a wide range of backgrounds, cultures and perspectives
- Assess risks and safety
- Develop safety plans
- Recognize and address barriers to ending and/or escaping abuse or accessing services
- Recognize the presence of medical or health problems
- Recognize and respond to the co-occurrence of domestic violence, substance use conditions and mental health conditions
- Manage stress and intervene in crisis situations
- Set appropriate boundaries with survivors
- Understand relevant legal and civil rights issues
- Coordinate services and collaborate with other providers
- Follow reporting mandates

**Adapted from the Council On Accreditation (COA)*

Personnel providing services in a group setting have the competencies and support needed to:

- Engage and motivate group members
- Educate group members
- Understand group dynamics
- Lead discussions
- Facilitate group activities

**Adapted from the Council On Accreditation (COA)*

Personnel who work directly with children or with survivors who have children, are knowledgeable about:

- Child development
- Possible effects of witnessing domestic violence
- Signs and symptoms of, and reporting requirements for, child abuse and neglect
- Collaborating with child protective services
- Non-violent discipline methods

**Adapted from the Council On Accreditation (COA)*

Personnel have an understanding of the laws pertaining to domestic violence. At a minimum the provider will be familiar with the following:

- State domestic violence laws and the response by the criminal justice systems
- Civil protection orders and restraining orders
- Court and probation policies and local law enforcement prosecution regarding domestic violence cases.

IV. Billable Units

Face-to-face time with the client

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

Face-to-face time Includes:

- Client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Crisis intervention and other goal directed interventions via telephone with the identified client family.
- Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

***Reminder:** Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

Translation or sign language Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

Concrete Services

Concrete funds of up to \$500 maximum per family are available to be spent on a wide variety of things that reduce the likelihood of placement. Therapist help access needed items, supports and services to reduce the likelihood of placement. Documentation of expenditure of funds must be maintained by the agency. –this could come into great use in Case management services such as relocating fees.

V. Rates

Face to Face Family Therapy Rate: _____
(2 or more members of the same family)

Face to Face Individual Therapy Rate: _____

Face to Face Group Therapy Rate: _____

Face to Face Case Management Rate: _____

Face to Face Group Case Management Rate: _____

Translation or Sign Language Rate: Actual Cost

Budget summary must be submitted for rate determination.

VI. Service Delivery

Ethical Standards

The term “provider” for this section applies to all staff and volunteers who work with batterers, including facilitators, co-facilitators and supervisors/trainers. All providers and administrators shall agree to and sign the following ethical standards:

AS A BIP PROVIDER OR ADMINISTRATOR, I DO AFFIRM THAT:

1. **I will make victim safety my first priority in working with those who batter.**
2. **I will make accountability of those who batter and program accountability my second priority.**
 - (a) I will immediately report to all appropriate legal authorities
 - Any additional violence (which includes but is not limited to physical violence, stalking, criminal trespass, and invasion of privacy) admitted to by a program participant.
 - Any suspected neglect or abuse of a child.
 - Any additional violence by a program participant sworn to by a third person, where such reporting will not further endanger the victim or witness.
 - (b) I will help prevent the unethical or unskilled practice of program intervention. I will report to the appropriate authorities any practice of program intervention by untrained or unqualified persons and any unethical conduct or unprofessional modes of practice by other program providers.
3. **I will collaborate with advocates against domestic violence in the design and overseeing of our program’s work.** I will welcome independent advocates to oversee, observe, and give feedback about the Program and services provided. I will participate in a coordinated community response against domestic violence. I will respect the limits of present knowledge in my public statements and not make any claims that are not substantiated by valid studies and statistics developed in collaboration with independent survivor advocates.
4. **I will conduct myself in my personal and professional life in a manner consistent with the principles of nonviolence and sobriety.** I will be vigilant regarding my own power and control issues, seeking to identify and change any sexist, racist, and homophobic attitude in my personal belief system. I will not use physical violence or tactics of abuse. If I have been physically violent, I will document completion of a certified program. I will be violence-free in my own

life for three years prior to facilitating in a program. I will not abuse drugs, including prescription drugs, or alcohol. I will be alcohol and drug free when performing program services. If I have an addiction problem (including substance, gambling and sexual addictions), I will undergo treatment and attain sobriety as a precondition to providing services. I will immediately disclose to the manager of my program if I am arrested for or have been convicted of any related charge, including, but not limited to, battery, domestic battery, stalking, criminal trespass, invasion of privacy, abuse or neglect of a child or protected adult, or any charge involving drugs, alcohol, gambling, pornography or other sex-related crime.

5. I will avoid personal, professional, or business relationships that conflict with the interest of the program and those it serves.

I will never engage in a relationship with a present or past program participant, a partner or ex-partner of a participant, or a family member of a participant that would in any way compromise their health and well-being or the complete integrity of the program, or that could impair professional judgment, or increase the risk of exploitation. I will avoid even the appearance of impropriety. I will not engage in any behavior with any of these persons that I would be unwilling to disclose fully to my colleagues, legal authorities, and the public. Specifically, I will not engage in sexual or romantic activities with participants, survivors, partners, or their family members for at least two years after last professional contact, and even then, not where such behaviors could reasonably contribute to the suffering of any person or the impairment of the program intervention effort. I will avoid working with participants who have close relationships with members of my family or significant business associates. I will not accept gifts or benefits from participants that might impair the integrity of the relationship or might invite special treatment.

6. I will treat all program participants, their partners, and survivors fairly. I will not discriminate because of race, class, age, religion, educational attainment, ethnicity, national origin, sexual orientation, or economic condition. I will act to guarantee that all persons, especially the needy, the disadvantaged, and those outside the cultural and language mainstream, have equal access to program resources and services. I will charge fees that are fair, reasonable, and consistent with a participant's ability to pay. I will fully explain from the beginning all program rules and policies affecting fee payment, enrollment, program standard, discharge, and completion. I will apply consistent program rules to all participants.

7. I will protect the confidentiality of participants, their partners, families, and survivors, subject to the primary duty of survivor safety. In doing so, I will follow the rules established by state and federal law, and by my program.

8. I will protect and enhance the professionalism, dignity, and integrity of the program. I will never participate in lessening program quality or duration for pecuniary or personal reasons. I will not offer services, testimony, or public pronouncements outside the recognized boundaries of my competency. I will not misrepresent my qualifications, education, experience, affiliations, or memberships.

**Adapted From the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

Therapist

Therapy provides any combination of the following kinds of services to the client:

- 1) Therapeutic Group Treatment for the batterer, survivor and/or child
- 2) Safety Planning
- 3) Individual and Family Therapy
- 4) Cognitive behavioral strategies
- 5) Family of origin/Intergenerational issues
- 6) Family structure and organization (internal boundaries, relationships, roles, socio-cultural history)
- 7) Stress management
- 8) Self-esteem
- 9) Communication skills
- 10) Conflict resolution
- 11) Behavior modification
- 12) Problem solving
- 13) Goal setting
- 14) Support systems
- 15) Parenting skills/training
- 16) Supervised visitation
- 17) Substance abuse
- 18) Crisis intervention
- 19) Participation in Child and Family Team Meetings
- 20) Family reunification

Caseworker

Case Management provides any combination of the following kinds of services to the client:

- 1) Education and skills-based Support Group for survivors and children
- 2) Assistance with transportation
- 3) Coordination of services
- 4) Advocacy
- 5) Community services information and assistance obtaining services
- 6) Community referrals and follow up
- 7) Family assessment
- 8) Child development education
- 9) Domestic violence education
- 10) Parenting education
- 11) Parent training with child present
- 12) Monitor progress of parenting skills
- 13) Supervised visitation
- 14) Budgeting and money management

- 15) Participation in Child and Family Team Meetings
- 16) Family reunification

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports provided no less than quarterly or more frequently as prescribed by DCS.

VIII. Service Access

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

NOTE: All services must be pre-approved through a DCS referral form. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral. Providers must have the ability to respond to referrals and to provide services 24 hours a day, 7 days a week.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DRUG TESTING AND SUPPLIES**

I. Service Description

These services are designed for individuals who are suspected of drug and/or alcohol use by DCS workers and Probation and require testing immediately. The vendor must provide all required supplies and courier services to transport all specimens, test results, and testing materials to and from any location within the referring county.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals), including chain-of-custody and/or testing procedures/results on an as needed basis.

The vendor shall provide Initial Testing and Gas Chromatography/Mass Spectrometry Confirmation (GC/MS) Testing (when the Initial Tests indicate a positive result) for any location within the referring county.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by laboratory personnel shall be fully documented using the proper chain-of-custody.

Testing for creatinine levels shall be conducted on all specimen samples. The vendor shall also conduct testing for total cannabinoids per mg of creatinine using spectrophotometric technology. The Vendor shall test for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also administer a specimen nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Testing shall not be conducted on any specimen without a legal chain-of-custody. All specimens found to be "Adulterated" or "Contaminated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The submitting location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were taken minus how many "Adulterate" or "Contaminated" specimens there were for the month.

Initial Testing

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following five substances utilizing the cut-off levels listed below:

Amphetamines*	500NG/ML
Cannabinoids	20NG/ML
Benzodiazepines	200NG/ML
Opiates	300NG/ML
Cocaine	300NG/ML

*The vendor must distinguish Methamphetamines from Amphetamines.

All negative samples will be retained for three weeks. A retention time extension may be requested based upon need.

Confirmation Testing

Confirmation Testing shall be conducted utilizing GC/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

Amphetamines*	500NG/ML
Cannabinoids	15NG/ML
Benzodiazepines	100NG/ML
Opiates	150NG/ML
Cocaine	150NG/ML

*The vendor must distinguish Methamphetamines from Amphetamines.

All positive samples shall be frozen and maintained for 365 days by the vendor. A retention time extension may be requested based upon need.

In situations where the source of the Amphetamine present in any specimen may come into question, the vendor must perform a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS.

Results Notification

The vendor shall notify the Department of Child Services and/or Probation of testing results via email on vendor letterhead. The results will also be sent by U.S. mail to the referring agency as well. The vendor shall gain approval from DCS for any changes in the results notification system.

The referring agency will be notified of negative test results within 24 hours of the test. The specified time frame is from delivery to the testing laboratory to the time of notification. Positive test results will be provided within 72 hours of the test.

Diluted results must be reported on the result form.

Courier System

The vendor will coordinate all courier services to transport all specimens, test results, and testing materials to and from any location within the referring county. Deliveries shall be made during regular working days, normally between the hours of 8:00 am and 5:00pm unless otherwise indicated. The vendor shall be responsible for the cost of all courier services provided under the contract.

The vendor shall provide courier services that maintain the legal chain-of-custody, throughout the State of Indiana within 24 hours of request of pick up.

The vendor shall provide postage paid mailers or next day delivery services for utilization at any location that desires to use this method as an alternative to the courier services. This shall be at no additional charge to DCS.

The vendor's courier system shall provide documented, legal chain-of-custody throughout the State of Indiana which includes, or is similar to, the following:

Vendor Courier	Operates Statewide/Same Day Delivery
Airborne Express	Operates nationwide providing next day delivery.
NOW Carrier	Operates throughout the State of Indiana providing same day delivery.
Direct Delivery	Operates throughout Central Indiana/Same Day Delivery.

Training

Prior to implementation, the vendor must provide training to the referring agency. The initial training shall be completed within six weeks of contract activation. The vendor will be responsible for conducting "Train the Trainer" sessions with appropriate staff of the referring agency. This will include Universal Precautions as well. This training will allow trained staff to train others in the county. The trainers will receive a training manual and all of the necessary handouts, videos or other material to accomplish all further training of staff.

Technical Support

A toll free 800 number will be available to all DCS local offices, in the State of Indiana to contact for technical support. Toxicologist shall be available during normal working hours via the 800 number, to provide technical assistance at no additional cost.

Supplies

The vendor shall provide the following supplies:

- 1) Male and female sample containers
- 2) Specimen donor labels
- 3) Evidence security tape
- 4) Evidence bags
- 5) Evidence chain-of-custody forms
- 6) All supplies required for mailing or next day delivery
- 7) Any additional supplies necessary for referring specimens to the laboratory.

II. Target Population

Services must be restricted to the following eligibility categories:

- 2) Children and families who have substantiated cases of abuse and/or neglect.
- 3) Children with a status of CHINS, and/or JD/JS
- 4) All adopted children and adoptive families

III. Goals and Outcome Measures

Goal #1

Services are provided timely as indicated in the service description above.

Outcome Measures

- 1) 100% of courier services will be provided within a 24hours of a request for pick up.
- 2) 100% of referring agencies will be notified of negative test results within 24 hours of the test.
- 3) 100% of referring agencies will be notified of positive test results within 72 hours of the test.

Goal #2

Services are provided as indicated in the service description above.

Outcome Measures

- 1)100% of proper legal chain-of-custody procedures will be maintained and will comply with Departmental Procedure, State and Federal law.
- 2)100% of all specimens will be tested for Amphetamines Cannabinoids Benzodiazepines Opiates Cocaine utilizing the cut-off levels listed above.
- 3) 100% of supplies will be provided to referring counties.

IV. Qualifications

A laboratory participating in DCS drug testing must comply with all applicable Department of Health and Human Service requirements.

V. Billable Units

Initial Testing of Specimens

Services include the initial testing of specimens and ensuring that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of delivery to the testing laboratory to the results notification.

Confirmation Testing for Positive Results

Services include the confirmation testing per specimen which confirms positive. This confirmation testing charge shall include confirmation of positive results for one or more substances in the same sample. Testing of specimens and ensuring that the chain of

custody procedure is followed to maintain the integrity and security of the specimen from time of delivery to the testing laboratory to the results notification.

Confirmation costs must be separated from initial screening costs. They are not to be bundled into one flat fee. Court costs should be built into the Confirmation Rate along with the reports back to referral source.

Rejected or Unfit Specimens

There will be no charge for the handling of rejected specimens or those otherwise unfit for testing.

Supplies

Actual cost of the supplies.

Translation or sign language

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

VI. Rates

Initial Testing: _____

Confirmation Testing: _____

Supplies: Actual Cost (Supply list with proposal)

Translation or sign language: Actual Cost

Budget summary must be submitted for rates determination.

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than quarterly or more frequently as prescribed by DCS.

VIII. Service Access

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

NOTE: All services must be pre-approved through a referral form from the referring DCS. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
EMERGENCY/MOBILE DRUG SCREENS/TESTS**

I. Service Description

These services are designed for individuals who are suspected of drug and/or alcohol use by DCS workers and probation and require screening immediately. The agency must have the capacity to respond to Emergency and Mobile screen referrals twenty-four (24) hours per day, seven days per week, including all holidays, including after-hours, weekends, and holidays. Emergency screen referrals may be completed at the bidding agency facility. Mobile screen referrals will require the provider to travel to any location within the referring County to complete the screen with the DCS referring worker.

It is expected that the referring worker and provider will work together to make arrangements to collect the screen in no more than twenty-four (24) hours of the first contact attempt from the referring worker.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals).

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Phencyclidine, Methadone, Creatinine, Propoxyphene, Oxycodone, and Methamphetamines. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

Testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total cannabinoids per mg of creatinine using spectrophotometric technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial Testing

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following five substances utilizing the cut-off levels listed below:

Amphetamines*	500NG/ML
Cannabinoids	20NG/ML
Benzodiazepines	200NG/ML
Opiates	300NG/ML
Cocaine	300NG/ML

*The vendor must distinguish Methamphetamines from Amphetamines.

Confirmation Testing

Confirmation Testing shall be conducted utilizing GC/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

Amphetamines*	500NG/ML
Cannabinoids	15NG/ML
Benzodiazepines	100NG/ML
Opiates	150NG/ML
Cocaine	150NG/ML

*The vendor must distinguish Methamphetamines from Amphetamines.

In situations where the source of the Amphetamine present in any specimen may come into question, the vendor must insure the performance of a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with DCS Procedure, State and Federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.

Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All specimens found to be "Adulterated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The submitting location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

Reporting requirements:

- Provider agency will be required to send email notification of positive and negative results to the referring worker within 24 hours of receipt and to mail original copies of all results within 24 hours of receipt from the laboratory.
- Email notification must be sent to the referring worker within 24 hours of all "failed attempts".
- Notification to the referring worker and termination of the referral after two (2) consecutive "failed attempts".
- Diluted results must be reported on the result form.

II. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect.
- 2) Minor children and caregivers suspected of drug use prior to adjudication.
- 3) Children with a status of CHINS, and/or JD/JS

III. Goals and Outcome Measures

Goal #1

Drug screens and their results will be provided to the referring worker in a timely fashion.

Outcome Measures

- 1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving the results of the drugscreen.
- 2) 100 % of written reports of the sample collections screen will be mailed/faxed to the referring worker within 24 hours of receipt of laboratory results.

Goal #2

Failed attempt forms based on two failed attempts of sample collection.

Outcome Measures

- 1) 100% of failed attempt alerts will be provided to referring worker within 24 hours following each failed attempt.

IV. Qualifications

Sample collection does not require the services of a certified drug abuse counselor. The person providing this service must be highly trained in sample collection and the chain of custody procedures to document the integrity and security of the specimen from time of collection until receipt by the laboratory.

V. Billable Units

Sample Collection:

Services include the collection of sample collections specimens and ensuring that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory.

Confirmation Testing (lab processing)

Services include the confirmation testing per specimen. This confirmation testing charge shall include confirmation of positive results for one or more substances in the same sample. Ensuring that the testing of specimens and the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of delivery to the testing laboratory to the results notification.

Confirmation costs must be separated from initial screening costs. They are not to be bundled into one flat fee. Court costs should be built into the Confirmation Rate along with the reports back to referral source.

Rejected or Unfit Specimens

There will be no charge for the handling of rejected specimens or those otherwise unfit for testing.

Failed Attempts:

- 1) Includes attempted scheduled sample collections with the identified client/family for which the client/family does not appear. Upon the second consecutive attempt, the provider must contact the referring DCS worker/Probation Officer to determine if continuation of services is appropriate.
- 2) Includes attempted unscheduled home visits if such visits are requested by the DCS via the Referral Form, the DCS Case Plan, or subsequent DCS Progress or Case Notes.
- 3) Wait time for a failed attempt must be no less than 15 minutes. A note must be left to inform the client/family that a contact attempt was made.
- 4) "Failed Attempts" are to be billed per occurrence.

Translation or sign language

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

VI. Rates

Sample Collection: _____
Confirmation Testing: _____
Failed Attempts: _____
Translation or sign language: Actual Cost

Budget summary must be submitted for rates determination.

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of contacts with the referred families/children including failed attempts.
- 3) Written reports as described in the service standard.

VIII. Service Access

Services must be accessed through a DCS referral. Referrals are valid for a maximum of two sample collection attempts unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

NOTE: All services must be pre-approved through a referral form from the referring DCS. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
RANDOM DRUG TESTING**

IV. Service Description

Random screens are designed for individuals who may or may not meet the criteria for substance abuse and may or may not actively participate in drug treatment services. Each random screen referral shall consist of ten (10) screens to be completed over a period of no less than ten (10) weeks and no more than six (6) months.

The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals).

All sample collections drug screens will be observed. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Phencyclidine, Methadone, Creatinine, Propoxyphene, Oxycodone, and Methamphetamines. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

Testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total cannabinoids per mg of creatinine using spectrophotometric technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial Testing

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following five substances utilizing the cut-off levels listed below:

Amphetamines*	500NG/ML
Cannabinoids	20NG/ML
Benzodiazepines	200NG/ML
Opiates	300NG/ML
Cocaine	300NG/ML

*The vendor must distinguish Methamphetamines from Amphetamines.

Confirmation Testing

Confirmation Testing shall be conducted utilizing GC/MS Technology on all samples

initially testing POSITIVE. The following cut-off levels shall be utilized:

Amphetamines*	500NG/ML
Cannabinoids	15NG/ML
Benzodiazepines	100NG/ML
Opiates	150NG/ML
Cocaine	150NG/ML

*The vendor must distinguish Methamphetamines from Amphetamines.

In situations where the source of the Amphetamine present in any specimen may come into question, the vendor must insure the performance of a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.

A letter to all referred clients will be required within three (3) calendar days of referral with instructions for contacting the agency immediately to begin screens. It is expected that the first screen will be collected within seven (7) calendar days of referral and each subsequent screen will be random. One or more toll free phone lines for clients to call daily to determine the day their screen is to be required. Agency must have a plan in place to modify the phone messages every day by 5 a.m., instructing clients whether to report that day for a screen or call again the next day.

The agency shall update the referring worker, by phone or email, within ten (10) calendar days of the date the referral was sent regarding the status of the referral. Agencies should inform the referring worker of the date the client completed their first screen or, if the client has not contacted the agency to complete their first screen, a consultation with the referring worker should be held to determine the next steps of services.

It is expected that the referring worker and provider agency will work together to develop a plan to determine the appropriate duration (10 weeks up to 6 months) of each referral. All random screen referrals shall include ten (10) screens and are to be completed over a period of no less than ten (10) weeks and no more than six (6) months. A second referral will be required if an excess of ten (10) screens per client are necessary.

Results Notification:

The vendor shall notify the FCM, probation and/or the DCS Service Consultant of testing results via email on vendor letterhead. The results will also be sent by U.S. mail to the referring county as well. The vendor shall gain approval from DCS for any changes in the results notification system.

The referring worker and DCS (if not the referral source) will be notified of positive test results within 24 hours of receiving test results from the testing laboratory. Negative test results will be provided within 72 hours of receiving test results from the testing laboratory.

No-show alert forms will be provided by the contracted agency to inform the referring worker of the client's failure to attend sessions based on within 24 hours off all "no-shows" and termination after two consecutive "no-shows". Any client who is administratively discharged must request a new referral from the referring worker to begin receiving services again.

The referring location shall be notified in writing if the specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

Diluted results must be reported on the result form.

Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All specimens found to be "Adulterated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The referring location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were attempted and completed minus how many "Adulterate" specimens there were for the month.

V. Target population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect.
- 2) Minor children and caregivers suspected of drug use prior to adjudication.
- 3) Children with a status of CHINS, and/or JD/JS

VI. Goals and Outcome Measures

Goal #1

Drug screen results will be provided to the referring worker in a timely fashion.

Outcome Measures

- 4) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving the results of the sample collections screen. Written reports of the sample collections screen will be mailed/faxed to the referring worker within 24 hours of receipt of laboratory results.

Goal #2

No Show forms based on two "No shows"

Outcome Measures

- 4) 100% of “No Shows” alerts will be provided to referring worker immediately following the select number of failed attempts.

VII. Qualifications

Sample collection does not require the services of a certified drug abuse counselor. The person providing this service must be trained in sample collection and the chain of custody procedures to document the integrity and security of the specimen from time of collection until receipt by the laboratory.

VIII. Billable Units

Sample Collection

Services include the collection of sample collections specimens and ensuring that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory.

Confirmation Testing (lab processing)

Services include the confirmation per specimen. This confirmation testing charge shall include confirmation of positive results for one or more substances in the same sample. Ensuring the testing of specimens and that the chain of custody procedure delivery to the testing laboratory to the results notification.

Confirmation costs must be separated from initial screening costs. They are not to be bundled into one flat fee. Courts costs should be built into the Confirmation Rate along with the reports back to referral source.

Rejected or Unfit Specimens

There will be no charge for the handling of rejected specimens or those otherwise unfit for testing.

Translation or sign language

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

VI. Rates

Sample collection: _____

Confirmation Testing: _____

Translation or sign language: Actual Cost

A budget summary must be submitted for rate determination.

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS/Probation referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports as stated in this service standard.

VIII. Service Access

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

NOTE: All services must be pre-approved through a referral form from the referring DCS. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.

Service Standard
Indiana Department of Child Services
Respite Care as a Prevention Service

I. Service Description.

Respite is a temporary interval of rest or relief from emotional exhaustion for parent(s), or caregivers of children, who are at risk of abuse and neglect. Respite care can be both crisis (emergency) and planned and in the case of preventative respite care, the service will originate with the onset of a crisis situation facing the caregiver. Care giving services may be in a free standing facility or given in or away from the child's home and may be for a few hours or extend to several weeks. Well planned and carried out respite services reduces stress and promotes the safety , well-being, and stability of families.

II. Target Population.

Indiana children from birth to age 16 who are at risk of abuse and/or neglect due to the onset of adverse circumstances facing the child's caregiver(s).

Children meeting the following conditions are not candidates for respite care:

- Children with the status of CHINS and/or JD/JS.
- Children with diagnosed emotional or behavioral disorders.
- Children with medical conditions that require constant monitoring.
- Children actively infected with a communicable disease.
- Children whose caregivers have alternative means of child care.

III. Goals and Outcome Measures.

Goal 1. Increased preservation of families through prevention services.

- A. Reduced number of reports of child abuse and neglect.
- B. Reduced number of CHINS-

Goal 2. The provision of respite service within a reasonable timeframe of a request for services.

- A. 100% of requests for services will be addressed within 4 hours of the call/referral for crisis respite and the next business day for planned respite.

Goal 3 Increased public awareness of the need for respite care and respite care providers in reducing child abuse and neglect.

- A. Increased number of respite care providers
- B. Increased usage of respite care

IV. Qualifications.

Administrative Standards:

1. Service providers shall have an organizational staffing chart that shows the lines of authority and communication channels.
2. A program director shall be appointed the responsibility to plan, staff and manage the provision of respite services.
3. Each employee shall receive a copy of the agencies personnel policies and practices.
4. The service provider shall comply with federal and state laws and regulations safeguarding client information and the personnel system shall comply with all applicable laws, statutes, regulations and equal employment opportunity mandates.
5. The service provider shall have a participant record system that includes, but is not limited to:
 - A written policy on the confidentiality and protection of records which states the use and conditions for removal of records, conditions for release of information and client authorization for release of information not otherwise authorized by law.
 - A written policy providing for the retention and storage of records as required for audit purposes and in the event the program discontinues operation.
 - Maintenance of records on the premises in a manner that is confidentially secure.
6. The service provider shall assure accessibility of services to persons with disabilities.
7. The service provider shall obtain and retain adequate insurance to guard against liabilities.
8. The service provider shall provide timely orientation to its employees that transmit the values philosophy and mission of this agency.
9. The service provider shall inform staff of laws, policies, procedures and individual reporting responsibilities regarding abuse, neglect and mistreatment of the person being cared for prior to the actual service delivery.
10. The service provider shall periodically assess the need for specific staff training programs.
11. The service provider shall have an evaluation system.
12. Have policies and procedures that address:
 - Program mission and philosophy.
 - Types of service.
 - Standards of care for children receiving services.
 - General emergency procedures.
 - Family and child rights and responsibilities.
 - Family confidentiality.

- Program entry and departure procedures.
- Record keeping.
- Medication administration.
- Transporting children.
- Staff behavior and expectations.
- Staff communication.
- Staffing ratios and job descriptions.

Program Standards:

Service Providers shall:

- Match children with respite providers who meet their needs, therapeutic or medical, and are familiar with their daily routines, preferred foods and activities.
- Maintain caseloads of agency worker at a reasonable number to ensure professional service to clients.
- Provide clear admission and discharge procedures which includes that a child will only be released to a person listed in the plan of care and the caregiver should call the agency immediately if they sense a safety risk.
- Provide information on the plan of care to respite providers.
- In emergency/crisis respite situations the agency shall have age appropriate interventions to help the child cope with the trauma and stress of the situation. This should be documented in the plan of care.
- Highly discourage corporal punishment and recommend, encourage, and if necessary, teach the use of disciplinary methods such as time outs, redirection and positive reinforcement.
- Limit number of children in respite home to 5 with no more than two under the age of 2. Exceptions can be made for sibling groups, if worker evaluates the provider home and recommends that a higher number of children can be provided quality care. This should be documented in the case file. If a child has therapeutic or medical special needs the number of children in a providers care should be evaluated and documented.
- Conduct satisfaction surveys with the family of the child in respite, the caregivers and the child if over 7 years old and able to respond.
- Offer training opportunities to staff and caregivers and keep a current list of other pertinent community trainings available.
- Maintain a 24 hour contact phone number with an on-call staff available.
- Provide caregiver with an on-call number and the child's health care contact information and known allergies.
- Be responsive to families needs. Families should have a choice of provider if possible and be able to request a change in provider.
- Instruct caregivers to report to the agency promptly any accidents, health problems or changes in appearance or behavior of a child in care.
- Have a method to assure client (child/child's family and caregiver) input on matters pertaining to program activities.

Caregivers providing respite care shall meet the following standards:

- Be at least 18 years of age, documented by birth certificate or driver's license.
- Be free of communicable diseases and/or other conditions that would pose safety or health risk to care recipients, documented by a signed statement.
- Documentation from a medical service provider may be requested.
- Possess the ability to follow directions and keep records, when required, of tasks being performed, documented by observation.
- Have adequate training for the level of child they care for.
- Have the ability to perform tasks/activities of the service to be provided, documented by written evidence of previous experience, competency –based testing, and training.
- Be a responsible, mature individual of reputable character who exercises sound judgment and displays the capacity to provide good care for children. This to be documented by competency-based testing, training or education, written evidence of previous experience.
- Possess the ability to communicate effectively with the person being cared for -documented by demonstrated ability.
- Shall not have been convicted in any jurisdiction for abuse, neglect, or any other crime that might pose a safety or health risk to the person receiving care. This is to be documented by a fingerprint analysis and criminal background check administered by the local police department ~~or~~ and the Indiana State Police and a check of the Sex Offender Registry.
- Three written references shall be provided by someone who has known the caregivers family for more than a year.
- Care providers should respect the culture, race, ethnicity, language, religion and sexual orientation of the children they provide respite for.

Respite services may be delivered in various settings:

- 1) Child(ren) needing respite services are taken to a respite caregiver's home
- 2) Respite caregivers may go to the child(ren)'s home to deliver services
- 3) Child(ren) may be taken to a respite care center

Caregiver's Home Standards:

When respite is in the caregiver's home the worker must submit a written statement that the home meets the following standards.

- The home shall be clean and maintained in a sanitary condition.

- The home shall have adequate heating, ventilation and lighting.
- The home shall be equipped with at least one smoke detector per floor and a minimum of one fire extinguisher per home.
- The home shall have a safe drinking water supply.
- Each child shall have a comfortable and clean place to rest or sleep.
- Potential hazards such as guns, medicines, etc. shall not be accessible to the child.
- The home shall have a method for communication such as a telephone.
- The home shall have a first aid kit.
- Caregiver's pets must not negatively effect a child in the home.

When the respite caregiver goes into the family home, the home must have the following:

- The caregiver will have access to a working phone.
- The caregiver will have information regarding domestic violence situations or other dangerous situations regarding the family or the home.
- The caregiver will have a list of emergency numbers pertinent to the local area as well as the contact information for the parents and the agency on-call number.
- The caregiver will be familiar with the plan of care.

Center-based respite care:

Center-based respite care is care that is provided in a residential care facility licensed by the state. Facilities providing respite care services are required to follow applicable licensing and certification rules.

Program Evaluation:

Each respite service provider shall conduct an internal evaluation at least annually of its operation and services. A written report of the evaluation must be kept on file. The evaluation shall include:

- Review of the performance of the program director and all staff.
- Review of the extent to which the program assisted clients (children and caregivers).
- Measurement of the achievement of goals and objectives.
- Assessment of the cost effectiveness of the program.
- Assessment of the relationship of the program to the rest of the community service network.
- Recommendations for improvement, corrective action of problem areas, and future program directions.

Ideally the program would evaluate the following for best practice:

- Reasons families are seeking service.
- Impact of services on family stress and quality of life.
- Family requests for service changes, expansion, and new service development.
- Family involvement in services.
- Program cost-effectiveness.
- Impact of the services on the community.
- Special activities (public awareness; fundraising).

V. Billable Units.

1. For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

2. Administrative cost to be paid on a monthly basis to support voluntary respite services.

VI. Rates.

Budget summary must be submitted for rate determination .

Case management: budget summary must be submitted for rate determination method.

VII. Service Delivery.

Respite services should be family friendly and easy to access. It should be clear what families need to do to receive services. The service options should be developed so that a variety of needs can be met and is flexible and responsive to the changing needs of families as possible.

Service providers must be able to accept calls 24 hours a day, seven days a week and during holidays. Once a call has been received, contact with the client must be initiated within four hours if there is a crisis situation and during the next business day if it is for planned respite.

Non business hours: Designated service provider staff shall receive calls via phone, cell phone or pager contact and will notify supervisory staff of the need for emergency care. Contact will be initiated with the client to arrange an intake at the service provider office, clients home, hospital or any other safe place.

Prevention respite services will be administered by Community Partners for Child Safety (CPCS) agencies.

VIII. Case Record Documentation.

Service providers shall maintain the following in a client case file:

- Dates of service and any reimbursement.
- Plan of care that meets the child's needs and identifies essential information to maintain the health, safety and welfare of the child, including any known allergies.
- Notes on behaviors, diet, routine, recreation and leisure activities (likes and dislikes) and any assistance needed for daily living skills if not age appropriate.
- A list of emergency contacts and phone numbers for child and a written agreement with the family regarding arrangements for emergency care. This should be signed by the parent and agency representative.
- An assessment of the client's needs relevant to the provision of respite services (client being both child and caregiver).
- Documentation of accidents, health problems or changes in appearance or behavior of a child in care and any follow up if it occurs.
- A discharge plan that includes the client's status (child and caregiver), recommendations for continuing care, referrals to community services agencies, and necessary follow-up when the client leaves the program.

IX. Service Access.

Service requests may come from the respite service seeker, from the Police, CPS, Emergency Room, or other community organizations or faith based organizations. The service is then initiated and agreed upon by the child's parent or guardian.

Agencies should distribute information regarding the program to hotlines, mental health facilities, hospitals, law enforcement, community programs, religious institutions, schools, public/private agencies or any other entity that would be a referral/information source for a family in need of respite.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TRUANCY TERMINATION

I. Service Description

The purpose of Truancy Termination services is to provide school drop-out prevention education, job readiness skills services, parent education, and family support services to youth and his/her family in order to reduce recidivism of delinquent youth and truants.

Family Support Services

Family support workers are to work with family members to identify reasons for youth's truancy and barriers to regular and positive school attendance as well as work with the school and Probation Officers to identify solutions and interventions necessary to ensure school attendance, increase youth's involvement in the school, and improve academic performance. Accomplishing these objectives may require the support worker to attend parent/teacher conferences and attend classes with the student. The support worker shall provide services in the areas of parent education and crisis intervention, including direct services. The support worker will be present as the Juvenile Court directs, including, but not limited to the Initial Hearing, where the worker will meet with the youth and family and complete the preliminary intake. The purpose of the preliminary intake is to gather basic information and provide a brief overview of participation in the program. The support worker is responsible for providing weekly written reports and to attend and be prepared to present at subsequent court hearings, written progress reports regarding each family's circumstances, participation in the program, school attendance rates, examples of school involvement, and academic performance. These reports shall reflect ongoing collaboration and cooperation among the family support workers, school social workers, and Probation Officers.

The family support workers shall conduct and complete comprehensive intake and assessment for each referral to create a Family Development Plan (FDP). The FDP will be shared with school social workers and Probation Officers to ensure that youth attends school and is favorably progressing academically.

Training Modules

Training modules consist of six (6) weekly skills-based classes in which the youth and parents are required to attend and complete. The family support worker will assess competence of knowledge of all program graduates, identify youth and families who may benefit by additional tutoring to strengthen their knowledge of skills and strategies in areas taught. Assessment of areas for continued improvement will be shared with school social workers, Probation Officers, and Juvenile Court.

Youth Modules

The following youth modules of Skills Based programming will be taught:

- "You are Somebody with Someplace to Go"/Personal Hygiene
- Truancy/College Awareness
- Conflict Resolution

- Relationships (peer to peer and peer to parent)
- Social Pressures and Substance Abuse
- Decision Making, Time Management, and Goal Setting

Parent Modules

The following parent modules of Skills Based programming will be taught:

- Role as a parent and self-esteem
- Understanding child growth and development/Sibling Rivalries
- Communication and listening skills/Relationships
- How to use effective discipline/Problem solving
- Anger management/Conflict resolution/Stress maintenance
- Teaching morals, values, and respect/How to prepare and manage a budget

Subsequent to the completion of the training modules the family support worker shall continue to work with the school social workers, probation officers, and the Juvenile Court to monitor families' well-being to ensure youth attend school. The support worker will conduct monthly activities designed to connect youth and families with positive sources of ongoing encouragement (i.e. career fairs, family dinners, age appropriate sports and/or entertainment events, etc.).

II. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

III. Goals and Outcomes

Goal #1

Ensure youth and parents participating in the modules are provided with the opportunity to learn the importance of regular school attendance.

Outcome Measures

- 1) 85% of youth and parents referred by the Juvenile Court shall complete six (6) skills-based modules.
- 2) 85% of those families completing the modules shall demonstrate increased knowledge resulting from participation in the skills-based modules.

Goal #2

Increase regular school attendance of youth completing the program.

- 1) 75% of youth completing the six week modules will attend school regularly through the term of this contract.

Goal #3

Juvenile Court and client satisfaction with services

Outcome Measures

- 1) Juvenile Probation/DCS satisfaction will be rated 4 and above on the Services Satisfaction Report.
- 2) 90% of clients will rate services as satisfactory or above on the satisfaction survey.

IV. Qualifications

Training Facilitator (Paraprofessional):

A high school diploma or GED and is at least 21 years of age. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with state policy concerning minimum care insurance coverage.

Family Support Worker:

Bachelor's Degree in social work, psychology, sociology, or a directly related human service field.

Supervisor (Professional):

Bachelor's Degree in social work, psychology, sociology, or directly related human service field plus three (3) years related experience.

Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per twenty (20) hours of direct client services provided, nor occur less than every two (2) weeks.

V. Billable Units

Roll all costs into Face to Face or Group rate.

Group rate

Groups are defined as a minimum of three (3) with no more than twelve (12) participants. The group rate must include preparation time, report writing, contacting families, and face-to-face contact in group with participating families.

Face-to-face time with the client :

(Note: Members of the client family are to be defined in consultation with the family and approved by the Juvenile Court. This may include persons not legally defined as part of the family).

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.

- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

Translation or sign language

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client.

VI. Rates

Face to Face rate: _____

Group rate: _____

Translation or Sign Language Rate: Actual Cost

Budget summary must be submitted for rates determination.

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/youth
- 3) Written reports no less than weekly or more frequently as requested by the Juvenile Court

VIII. Service Access

Services must be accessed through a Juvenile Probation/DCS referral unless otherwise specified. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the Juvenile Probation/DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

NOTE: All services must be pre-approved through a Juvenile Probation/DCS referral form. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TUTORING/LITERACY CLASSES**

I. Service Description

Tutoring/literacy and math services will be provided to raise the academic performance of school aged youth to a level consistent with state education standards.

Services shall be provided in a manner that is age and developmentally appropriate, and consistent with the child's academic ability and learning style, interpersonal characteristics and special needs. Children will be connected as appropriate with both formal and informal community supports, services and activities that promote their literacy skills. The child's characteristics such as race, culture, ethnicity, language and personal history including child abuse and neglect will be considered when choosing or designing program interventions, materials and curriculum. The provider will develop an education plan to address the child's literacy and math needs.

A variety of activities and lessons shall be available to afford choice. Activities and lessons shall promote literacy skills and academic development and should demonstrate well-planned, flexible and responsive services. Services should include regular use of external resources such as libraries, museums and community educational sites. Services may also incorporate the use of video games and computers. The use of television and videos shall be strictly limited to a minimal portion of the child's participation. Video games, computers, television and videos should be age and developmentally appropriate, supportive of the child's educational goals, and should be monitored at all times.

The provider will develop a plan to engage the child and caregiver in the process, as well as the educator, and this plan will accommodate persons who are difficult to engage. The provider will clearly and frequently communicate and coordinate the child's education plan goals with the caregiver and educator.

Treatment Modality

Tutoring/literacy and math services shall be provided through direct one-on-one sessions or in small groups of 2 to 4 children who are matched by ability. Sessions shall be provided at least twice a week and may be up to 60 minutes in duration, depending upon the age of the child and type of activity. Services should occur in locations that that promote learning, are large enough for the child to concentrate without being disturbed by others, and allow for meaningful and direct assistance. Services may take place after school, on weekends and/or during the summer.

Tutoring/literacy and math services shall incorporate evidence-based strategies that improve student achievement. Sessions shall be divided into segments, including: 1) an opening activity to set the stage, 2) activities based on individual learning goals, 3) opportunities to develop and practice skills, and 4) a closing activity. All sessions shall

include opportunities for the child to experience success and to progress. The provider may suggest home activities as appropriate.

Assessment

The provider will ensure the child receives an initial assessment in order to determine child specific learning needs, no later than 10 days after being referred to services to promote the timely initiation of services. The provider will make reasonable attempts to discover previous assessments and to utilize the findings of those assessments in conjunction with the provider's own assessment. Assessments shall include the use of standardized tools to obtain a baseline measurement and will at a minimum identify the following:

- Learning disabilities and/or impairments in cognitive functioning due to child abuse or neglect or involvement with child welfare services
- Academic strengths and needs
- Level of ability compared to expected grade level

Services will be provided within the context of the Department of Child Services' practice model with involvement in Child and Family team meetings if invited. An education plan will be developed and based on the agreements reached by means of the assessment and Child and Family Team Meeting (CFTM). Services will be in coordination with the child's Individualized Education Plan (IEP) if present, and the provider should participate in IEP conferences with educators.

Education Plan

Comprehensive education plans will be developed based on the assessment and will contain both long-term and short-term goals. Plans at a minimum will:

- Include input from the child, caregiver and the educator
- Reflect underlying needs and goals
- Be tailored to the child's strengths, needs, available resources and unique circumstances
- Build on realistic possibilities and options
- Identify strategies for lessening the effects of disabilities and/or impairments in cognitive functioning due to child abuse or neglect, if present
- Promote reading and math achievement at a level consistent with state education standards
- Be consistent with the child's Individualized Education Plan (IEP), if one is present
- Support and/or build upon what the child is learning through their primary education program
- Respond flexibly to the child's changing needs

The provider will evaluate the child's progress toward achieving identified goals and will regularly incorporate the use of standardized performance measurement tools to track progress and adjust tutoring/ ~~and~~ literacy and math activities. The provider will assist the child and caregiver in realizing ways of generating and maintaining gains. The provider will document progress and participation.

The Books for Youth Program, sponsored by the Indianapolis Colts, the Indiana Department of Child Services and the Indianapolis Marion County Library will be accessed by providers in participating counties.

Services must be available to participants who have limited daytime availability.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals).

Provider must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the contract.

II. Target Population

Services must be restricted to the following eligibility categories:

- 2) School aged children who have substantiated cases of abuse and/or neglect and have been identified as needing tutoring/ literacy and math services
- 3) Children with a status of CHINS, and/or JD/JS, or
- 4) All adopted children.

III. Goals and Outcome Measures

Goal#1

Timely provision of services for the youth and regular and timely communication with referring worker.

Outcome Measures:

- 1) 95% of all youth referred will have face-to-face contact with the provider within 10 days of the referral.
- 2) 95% of all youth will have a written education plan within 30 days of the referral.
- 3) 100% of all youth will have monthly written summary reports prepared and sent to the referring worker.

Goal #2

Child has improved academic and/or literacy performance

Outcome Measures:

- 1) 90% of children improve academic and/or literacy performance as evidenced by pre and post-testing
- 2) 90% of children improve overall school performance as measured by grade point average or other standard indicators
- 3) 100% of children participate actively in the goals of their education plan as evidenced by provider documentation

Goal #4

DCS and youth satisfaction with services

Outcome Measures:

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the youth who have participated will rate the services “satisfactory” or above.

IV. Qualifications

Direct Worker:

Tutoring services may be provided by workers with a Bachelor's degree or at least 60 hours of post secondary credit hours in education, social work, psychology, or a related field. Intermediate computer skills (e-mail, internet, word processing, etc.) and knowledge of state education standards are preferred. Workers are required to pass a state background check.

Supervisor:

Bachelor's degree in education, social work, psychology, or a related field and 5 years experience tutoring children. Knowledge of state education standards is required.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

Worker Qualities:

Providers working directly with children have the competencies and support needed to:

- Engage, empower and communicate effectively, respectfully and empathetically with children and families from a wide range of backgrounds, cultures and perspectives
- Develop plans to meet the child's literacy needs

- Recognize and identify the presence of cognitive impairments due to child abuse and neglect and learning disabilities
- Collaborating with other disciplines and community resources
- Advocate for the child during Child and Family Team Meetings and Individualized Case Plan (IEP) conferences

Providers working directly with children are knowledgeable about:

- Child development
- Behavior management
- Learning disabilities
- Possible effects of child abuse and neglect on cognitive functioning
- The Individualized Education Plan (IEP) and its use in education
- Educational resources within the community
- Tutoring techniques

V. Billable Units

All other costs must be into Face to Face or group.

Group Rate:

Groups are defined as a minimum of three (3) with no more than twelve (12) unrelated participants. The rate must include preparation time, report writing, contacting families, and face-to-face contact in group with participating families.

Face-to-face time with the client (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family):

Face-to-face time includes:

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

***Reminder:** Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the

following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

Translation or sign language Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

VI. Rates

Group: _____

Face-to-Face: _____

Translation or Sign Language: Actual Cost

Budget summary must be submitted for rate determination.

VII. Service Delivery

Provider staff caseloads shall support the achievement of child outcomes. Caseloads should be based on the qualifications, competencies and experience of the worker, and the level of supervision needed, as well as on service volume, including the work and time required to accomplish job responsibilities.

VIII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports provided no less than quarterly or more frequently as prescribed by DCS.

IX. Service Access

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

NOTE: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.